Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services
160 Allen Street
Rutland, VT 05701
802.775.7111

Outpatient MRI Order/ Prescreening Questionnaire

Upon completion, please fax to central scheduling at 776-3301.
(For Breast MRI only, fax to Breast Care Program at 747-6595.)

Patient Name: _____ Date of Birth: _____
Patient Phone (8am-4pm) _____ Referring Physician: _____
Can we leave a message? ☐ Yes ☐ No **Physician Signature**: _____
(If not, please have patient call us the next business day 747-1707) **Date:_____ Time**: _____
*Required: **Patient height**: _____ **Patient weight:** _____ (weight limit 350lbs)
Type of MRI ordered: _____ IV contrast ☐with ☐ without ☐with and without
Diagnosis/What are we looking for? _____
(Symptomatology/Findings) _____

☐77002 Fluoroscopy for needle placement for MR arthrogram injection ☐ MR Arthrogram _____

YES	NO	PLEASE ANSWER EACH QUESTION
		Does patient have a pacemaker (or pacemaker wires in chest), implantable cardiovascular device (ICD) or external device (insulin pump)?
		Does patient have a brain aneurysm clip? If yes, call MRI at 747-1707 before scheduling.
		Does patient have a fear of close places (claustrophobia)? If yes ,see reference document. In: Support needed?: ☐ None ☐ Oral -patient will bring ☐ IV Sedation - Order required
		Is patient ≥ 60 years of age? CREATININE_____ DATE_____ **If the patient is over 60years of age and receiving contrast a Creatinine is required (within 90 days) if patient is receiving contrast.**
		Is patient diabetic? CREATININE_____ DATE_____ **If the patient is diabetic and receiving contrast a Creatinine is required (within 90 days) if patient is receiving contrast.**
		Has patient ever had eye surgery that resulted in implants other than cataract lens? If yes, what/when? _____
		Has patient ever had ear surgery that resulted in a metal cochlear implant? If yes, call MRI with type of implant. _____
		Has patient ever had an accident with metal in the eye? If yes, have they had an MRI since? If not, patient must have an x-ray before the MRI (can be done 1-2 days prior or before 5 pm on day of exam).
		Has patient had any recent surgery, in past 4-6 weeks Date: _____ Type of recent surgery: _____
		Does patient have any implanted devices (other than cataract lenses)? If yes, what? _____
		Is patient pregnant or think she may be pregnant?
		Is the patient a nursing mother?
		Does patient have difficulty lying flat? If so, which: ☐ Back or ☐ Stomach
		ONLY FOR MRI OF BREAST:
		Is patient on hormone replacement therapy (HRT)? If yes, patient needs to be off HRT for 6 weeks before MRI is performed. Date of last dose: _____
		Does patient still have a menstrual cycle? First day of last menstrual period: _____ Date next period expected: _____

Above portion completed by:_____ **Date:_____ Time:** _____

TO BE COMPLETED BY CENTRAL SCHEDULING:

MRUN: _____ Booked by: _____ Time:____ Date: _____ **MRI Time:____ Date:** _____