Rutland Regional Medical Center

Outpatient MRI Order/ Prescreening Questionnaire

Upon completion, please fax to central scheduling at (802) 776-3301.
(For Breast MRI only, fax to Breast Care Program at (802) 747-6595)

Patient Name: _____ Date of Birth: _____
***Required:** Patient Height: _____ Patient Weight: _____ (exam limit 400 lbs)
Patient Phone (8am-4pm): _____ Can we leave a message? ☐ Yes ☐ No **Call MRI if over 400lbs**
If not, please have patient call us the next business day (802)747-1707
Type of MRI ordered: _____ IV contrast ☐with ☐without ☐with and without
Diagnosis/Symptoms: _____
What are we looking for? _____
Referring Provider: _____

Time: _____ Date: _____ Provider Signature: _____

☐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 or medication pump), or wear a continuous glucose monitor? If yes, which device_____.
		Does patient have a brain aneurysm clip? If yes, call MRI at (802)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-Provider must sign MRI Screening form
		Has patient ever had eye surgery that resulted in implants other than cataract lens? If yes, what and when? _____
		Has patient ever had ear surgery that resulted in a metal cochlear implant? If yes, call MRI with type of implant (802)747-1707
		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 surgery, in past 4-6 weeks Date: _____ Type of surgery: _____
		Does patient have any implanted devices (other than cataract lenses)? If yes, what? _____
		Is patient pregnant or think she may be pregnant? ☐ Yes ☐ No
		Is the patient a nursing mother? ☐ Yes ☐ No
		Does patient have difficulty lying flat? If so, which: ☐Back or ☐Stomach
		ONLY FILL OUT BELOW FOR MRI OF BREAST: * Breast MRI Weight limit 300lbs*
		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: _____

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

To be completed by Central Scheduling:

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

Patient Label