3T 28 May @ 1045/1015

Personal Data - [redacted] Printed: 03 May 2019

P R O C E D U R E W O R K S H E E T
TRIPLER ARMY MEDICAL CENTER -- DIAGNOSTIC SERVICE

0 sed MC

[redacted] Rank: [redacted]
Age:
Sex:

daytshift

[redacted]

Please schedule with mother in the month of May if able.

May 6-10 ok

1 year old infant with history of HIE with VAD in place. Please perform HASTE

[redacted]

***** NEURO IMAGING PROTOCOL *****		
__ Brain	__ MRA Stroke/TIA	__ Neck Soft Tissue
__ Temp. Lobe Seizure	__ MRA Dissection	__ Brachial Plexus
__ Tumor/Infection	__ MRA Aneurysm	__ Spectroscopy
__ Multiple Sclerosis	__ C-Spine	__ Stealth
__ Cranial Nerves/Parotid	__ T-Spine	__ Cine CSF Flow
__ IAC	__ L-Spine	__ TMJ
__ Pituitary	__ Screening Spine	__ Other 1030
__ Orbits	__ Scoliosis Spine	
***** BONE IMAGING PROTOCOL *****		
__ Shoulder Anatomy	__ Hand	__ Tibia/Fibula
__ Shoulder Arthrogram	__ Pelvis (Bone)	__ Ankle 1045
__ Humerus	__ Hip Arthrogram	__ Foot
__ Elbow Anatomy	__ Unilateral Hip	__ Tumor/Osteomyelitis
__ Elbow Arthrogram	__ Bilateral Hip	__ Knee Preop
__ Forearm	__ Femur	__ Other
__ Wrist	__ Knee Anatomy	__ Confirm Xray Compl
__ Wrist Arthrogram	__ Knee Arthrogram	__ Place Marker 18
***** BODY IMAGING PROTOCOL *****		
__ Chest Anatomy	__ Adrenal	__ Prostate
__ Chest Aorta Dis	__ Kidney Tumor	__ Scrotum/Penile
__ Chest Tumor	__ Kidney MRA	__ Abd Aorta MRA
__ Aortic Arch	__ Pelvis Anatomy	__ Run Off MRA
__ Cardiac	__ Pelvis Other	__ IVC/Venogram
__ Liver Eovist	__ UFE	__ Veins (Ch/Abd/Ext)
__ Liver Gadavist	__ MRI, Urography	__ Breast Tumor
__ MRCP LTD	__ Fetal	__ Breast Implant
__ Liver/Pancreas	__ Enterography	

Special Instructions

✓ No other children under 1
Sched 5/8 @ 9:48 am
Offered 24 May (sched conflict)
29 May (sched conflict)

No metal

Ht	25-27	K	None	O	
Wt	9lbs 13oz	M	NO	C	NO

Nam[redacted] Today's Date[redacted]

Welcome to the Tripler Army Medical Center Radiology Department. Your physician has requested that you receive an MRI examination. To help us perform the highest quality study, please complete this form.

1. What is your current complaint or problem and when did it start?
Brain problems @ B.Hth. MRI are to check for development/changes

2. Was this associated with injury? If yes, please describe the activity that led to injury Brain Bleeds, Spinal Fluid Blockage

3. Have you ever had cancer? Yes__ No ✓ If yes, what part of the body?

How long ago was it diagnosed? _____ Did you have radiation therapy? ____

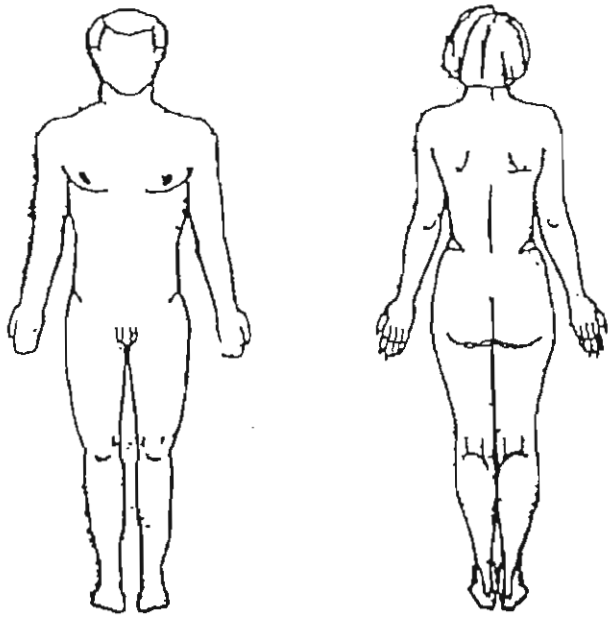
4. Have you had previous MRI or CT scan? Yes ✓ NO ____ If yes, what did it show

5. Have you had prior surgery in this area? If yes, when and what type?
YES, a Drain was put in the top of the head and once to fix a Brain bleed

6. Do you have any other medical problems such as high blood pressure or diabetes?

Yes____ No ✓

7. Please draw on the diagrams the location of you pain, numbness, or weakness:



Right Left Left Right

MAGNETIC RESONANCE (MR) ENVIRONMENT SCREENING FORM FOR INDIVIDUALS*

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. Be advised, the MR system magnet is ALWAYS on.

*NOTE: If you are a patient preparing to undergo an MR examination, you are required to fill out a different form.

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☑ No ☐ Yes
   If yes, please indicate date and type of surgery: Date ____/____/____ Type of surgery_____
2. Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)? ☑ No ☐ Yes
   If yes, please describe: _____
3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☑ No ☐ Yes
   If yes, please describe: _____
4. Are you pregnant or suspect that you are pregnant? ☑ No ☐ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment or MR system room if you have any question or concern regarding an implant, device, or object.

Please indicate if you have any of the following:

- ☐ Yes ☑ No Aneurysm clip(s)
- ☐ Yes ☑ No Cardiac pacemaker
- ☐ Yes ☑ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☑ No Electronic implant or device
- ☐ Yes ☑ No Magnetically-activated implant or device
- ☐ Yes ☑ No Neurostimulation system
- ☐ Yes ☑ No Spinal cord stimulator
- ☐ Yes ☑ No Cochlear implant or implanted hearing aid
- ☐ Yes ☑ No Insulin or infusion pump
- ☐ Yes ☑ No Implanted drug infusion device
- ☐ Yes ☑ No Any type of prosthesis or implant
- ☐ Yes ☑ No Artificial or prosthetic limb
- ☐ Yes ☑ No Any metallic fragment or foreign body
- ☐ Yes ☑ No Any external or internal metallic object
- ☐ Yes ☑ No Hearing aid
  (Remove before entering the MR system room)
- ☐ Yes ☑ No Other implant_____

IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beeper, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Print name _____ Signature _____

☒ MRI Technologist ☐ Radiologist ☐ Other _____

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MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

OTSG APPROVED *(Date) (YYYYMMDD)*

Reason for MRI and or Symptoms _____

Referring Physician _____ Telephone (____) ____-____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☑ Yes
   If yes, please indicate the date and type of surgery:
   Date 02 / 28 / 2018 Type of surgery Brain Surgery
   Date ____/____/____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ No ☑ Yes
   If yes, please list:

	Body part	Date	Facility
MRI	Head	/ /	TAMC
CT/CAT Scan		/ /	
X-Ray		/ /	
Ultrasound		/ /	
Nuclear Medicine		/ /	
Other _____		/ /	

3. Have you experienced any problem related to a previous MRI examination or MR Procedure? ☑ No ☐ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc)? ☑ No ☐ Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☑ No ☐ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ☑ No ☐ Yes
   If yes, please list: _____
7. Are you allergic to any medication? ☑ No ☐ Yes
   If yes, please list: _____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☑ No ☐ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ☐ No ☑ Yes
   If yes, please describe: Had Seizures as a baby but None Since

For female patients:

10. Date of last menstrual period: ____/____/____ Post menopausal? ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
    If yes, please describe: _____
14. Are you currently breastfeeding? ☐ No ☐ Yes

PREPARER

DEPARTMENT/SERVICE/CLINIC

DATE *(YYYYMMDD)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle, grade, date, hospital or medical facility)*

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

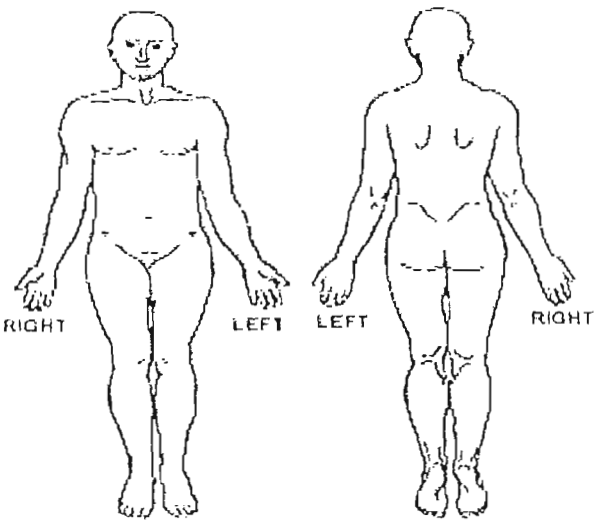
☐ TREATMENT

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

☐ Yes	☑ No	Aneurysm clip(s)
☐ Yes	☑ No	Cardiac pacemaker
☐ Yes	☑ No	Implanted cardioverter defibrillator (ICD)
☐ Yes	☑ No	Electronic implant or device
☐ Yes	☑ No	Magnetically-activated implant or device
☐ Yes	☑ No	Neurostimulation system
☐ Yes	☑ No	Spinal cord stimulator
☐ Yes	☑ No	Internal electrodes or wires
☐ Yes	☑ No	Bone growth bone fusion stimulator
☐ Yes	☑ No	Cochlear, otologic, or other ear implant
☐ Yes	☑ No	Insulin or other infusion pump
☐ Yes	☑ No	Implanted drug infusion device
☐ Yes	☑ No	Any type of prosthesis (eye, penile, etc)
☐ Yes	☑ No	Heart valve prosthesis
☐ Yes	☑ No	Eyelid spring or wire
☐ Yes	☑ No	Artificial or prosthetic limb
☐ Yes	☑ No	Metallic stent, filter, or coil
☐ Yes	☑ No	Shunt (spinal or intraventricular)
☐ Yes	☑ No	Vascular access port and/or catheter
☐ Yes	☑ No	Radiation seeds or implants
☐ Yes	☑ No	Swan-Ganz or thermodilution catheter
☐ Yes	☑ No	Medication patch (Nicotine, Nitroglycerine)
☐ Yes	☑ No	Any metallic fragment or foreign body
☐ Yes	☑ No	Wire mesh implant
☐ Yes	☑ No	Tissue expander (e.g., breast)
☐ Yes	☑ No	Surgical staples, clips, or metallic sutures
☐ Yes	☑ No	Joint replacement (hip, knee, etc.)
☐ Yes	☑ No	Bone joint pin, screw, nail, wire, plate, etc.
☐ Yes	☑ No	IUD, diaphragm, or pessary
☐ Yes	☑ No	Dentures or partial plates
☐ Yes	☑ No	Tattoo or permanent makeup
☐ Yes	☑ No	Body piercing jewelry
☐ Yes	☑ No	Hearing aid
		(Remove before entering MR system room)
☐ Yes	☑ No	Other implant _____
☐ Yes	☑ No	Breathing problem or motion disorder
☐ Yes	☑ No	Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Print name

☒ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other_____