McLaren Flint
MRI
HOSPITAL INPATIENT SCHEDULING FORM
Phone: 342-4360 Fax: 342-2100

Phone:_____ Room #:_____

Patient Name: _____ Height:_____ Weight:_____

Ordering/Attending Physician:_____

Nursing Station Contact Person:_____

Type of Exam Ordering: _____

(If pt. is having MRCP, must be NPO for 5 hours prior to exam)

Diagnosis/R/O: _____

Signs & Symptoms:_____

Is the patient on telemetry? ☐ Yes ☐ No Can the patient come off telemetry for the exam? ☐ Yes ☐ No

Safety Clearance Questions:

Cardiac Defibrillator (ICD)	☐Yes	☐ No	If yes, patient cannot have MRI
Pacemaker	☐Yes	☐ No	If yes, Model # and Brand
Brain Aneurysm Clips	☐Yes	☐ No	If yes, need make and model
Brain Surgery	☐Yes	☐ No	
Claustrophobic	☐Yes	☐ No	
Does the patient need sedation? Sedation Hours: M-F 8-4:30 Sat 8-12	☐Yes	☐ No	If yes, ☐IV or ☐Oral? If IV sedation, patients need to be NPO for 6 hours prior.
Does the patient need pain medicine prior to exam?	☐Yes	☐ No	
Ear/Eye Surgery	☐Yes	☐ No	
History of Cancer	☐Yes	☐ No	
Primary:_____			
Heart Surgery	☐Yes	☐ No	
Metal in Eyes/Ears/Body	☐Yes	☐ No	
Neurostimulator	☐Yes	☐ No	If yes, make and model
Oriented/Cooperative	☐Yes	☐ No	
Pregnant	☐Yes	☐ No	
Prosthesis	☐Yes	☐ No	Type:_____
Spine Surgery	☐Yes	☐ No	
Surgical Implants	☐Yes	☐ No	
Kidney Disease	☐Yes	☐ No	If yes, GFR_____ Dialysis?
Patient on a ventilator	☐Yes	☐ No	
Is patient ambulatory?	☐ Walk ☐ Wheelchair ☐ Stretcher		

Paragon Patient Profile Reviewed for: Previous Procedures Devices/Implants	☐Yes	☐ No	
Is patient displaying altered mental status and/of have a history of dementia?	☐Yes	☐ No	If YES review form with Family or Appropriate Indidvual: Name _____ Relationship _____

Interviewer's Signature: _____ Date/Time_____Floor____

Upon receipt of this form via fax, MRI will call the floor with patient's exam time.

HOSPITAL INPATIENT SCHEDULING FORM
17846 (Rev. 11.19)

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PT.

MR.#/P.M.

DR.