

Facility: _____



RADIOLOGY PATIENT SAFETY FLOW SHEET – NON-IONIC CONTRAST MRI SCAN

Location: _____ Ext: _____ Date: _____ Unit: _____

ID by: _____, via: Name ☐ DOB ☐ MR# ☐ ID Band IV Contrast Checklist: ☐ Contrast Required

*History of Kidney problems: ☐ No ☐ Yes, Describe: _____

BUN _____ CREATININE _____ GFR _____ *Alert values: GFR less than 30

Claustrophobic: ☐ No ☐ Yes, Describe: _____

Pre-medications given: ☐ No ☐ Yes, list: _____

NPO since: _____

Allergies: ☐ No ☐ Yes, Describe: _____

Asthma: ☐ No ☐ Yes, list meds: _____

Diabetes: ☐ No ☐ Yes, list meds: _____

*Pregnant: ☐ No ☐ Yes ☐ LMP _____ Breastfeeding: ☐ No ☐ Yes

*Has the patient ever experienced a problem during a radiology exam? ☐ No ☐ Yes, describe: _____

*If yes, consult with Radiologist required prior to exam.

Please Complete As Needed

Time	BP	HR/ Pulse	ECG	RR	Pain**	Mental Status***	Medication Orders
							*Do not complete if electronically ordered/prescribed
							<input type="checkbox"/> 18 <input type="checkbox"/> 20 <input type="checkbox"/> 22 gauge <input type="checkbox"/> _____ IV Site: _____
							<input type="checkbox"/> Magnevist _____ ml I.V. at _____
							<input type="checkbox"/> Multihance _____ ml I.V. at _____
							<input type="checkbox"/> Lexiscan _____ ml I.V. at _____
							<input type="checkbox"/> Other _____
Additional IV fluids given: <input type="checkbox"/> no <input type="checkbox"/> yes, <input type="checkbox"/> NS <input type="checkbox"/> LR <input type="checkbox"/> D5W Total amount: _____							<input type="checkbox"/> Other _____
Blood Products given: <input type="checkbox"/> no <input type="checkbox"/> yes, total: _____ PRBC _____ FFP _____ Platelets _____ PCC _____ units							I have reviewed the patient's current medications
**Pain: 0=no pain, 10= severe pain							Radiologist/LIP/Designee Signature:
***M/S: 1=alert 2=drowsy/cooperative 3=drowsy/uncooperative 4=unresponsive/self-airway 5=unresponsive/w/o self-airway							Print: _____ Sign _____
							Date: _____ Time: _____ am/pm

Contrast Verification Confirmed: ☐ Correct Patient, Contrast Agent, Dose, and Route Confirmed.

Signature/ Title: _____ Date: _____ Time: _____ am/pm

Documentation / Patient Teaching:

- ☐ No adverse effect observed during study.
- ☐ Patient given verbal instructions to drink 6-8 glasses of water today
- ☐ Patient advised to report delayed adverse reaction to MD or come to ED
- ☐ Instruction post-study sheet given to patient ☐ Routine ☐ Diabetic
- ☐ Breastfeeding to be withheld for 48 hrs after receiving contrast

Notes: _____

Signature/ Title: _____ Date: _____ Time: _____ am/pm

* Radiologist Signature (only when consult required) _____ Date: _____ Time: _____ am/pm