NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
nyc.gov/hhc

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, Primary Physician, or Designee required prior to exam.**

Please Complete As Needed

Time	BP	HR/ Pulse	ECG	RR	Pain**	Mental Status***

Additional IV fluids given: ☐ no ☐ yes, ☐ NS ☐ LR ☐ D5W

Total amount: _____

Blood Products given: ☐ no ☐ yes, total: _____

PRBC _____ FFP _____ Platelets _____ PCC _____ units

****Pain:** 0=no pain, 10= severe pain

*****M/S:** 1=alert 2=drowsy/cooperative
3=drowsy/uncooperative 4=unresponsive/self-airway
5=unresponsive/w/o self-airway

Medication Orders
***Do not complete if electronically ordered/prescribed**

☐18 ☐ 20 ☐ 22 gauge ☐ _____ IV Site: _____

☐ Magnevist _____ ml I.V. at _____

☐ Multihance _____ ml I.V. at _____

☐ Lexiscan _____ ml I.V. at _____

☐ Other _____

☐ Other _____

I have reviewed the patient's current medications

Radiologist/Primary Physician/LIP/Designee Signature:

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

Notes: _____

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

* **Radiologist, Primary Physician/LIP/Designee Signature (only when consult required):**

Print: _____ Sign: _____ Date: _____ Time: _____ am/pm