

Workflow of a New Study at MR Service Center—MR Tech assisted scan

Point of contact:

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At least 1 week prior to the scan day:

- Register an iLab account (as a PI or a lab member) for scheduling MR scanner.
- Submit an Access Request at iLab.
- Contact Dr. Miao for MR protocol setup, functional MRI paradigm, and phantom test. A unique protocol name will be assigned, which should be used for future correspondence and in iLab.
- Email MRI techs to provide details of the study:
 1. Accommodation Inquiry Form
 2. discuss the scan duration to book
- After all the steps above are finished: Schedule the scanner at iLab.

When recruiting the participants:

- Complete the MRI Screening Form during the initial recruitment process. All the questions should be asked and answered in detail. Let the MRI techs know if any concerns at least 2 business days prior to the scan day.
- Please ensure your patient is registered in the CRMS system.
https://ictr.johnshopkins.edu/programs_resources/programs-resources/i2c/clinical-research-management-system-crms/

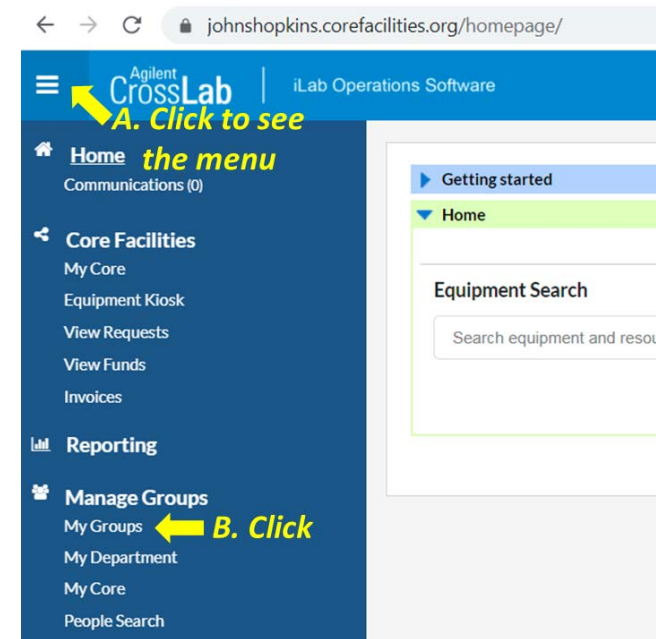
On the scan day

- Coordinators should bring:
 1. MRI Screening Form
 2. De-Identification form
- If you do NOT need a report:
 - Coordinators should bring the participant to the MRI Dept. **0.5 hour** before the scheduled scan time and have a seat in the waiting area.
- If you need a report:
 - An order will need to be placed in EPIC using the IMG Code 4338. This is a Research w/ Read Code.
 - Prior to going to the MRI Dept., you will need to go to Room B138 (which is down the hall towards Nuclear Medicine) to register your pt. Please give the completed MRI screening form to the registrar. After that is completed, please proceed to the MRI Dept **0.5 hour** before the scan time.
- ❖ When you arrive at MRI Dept. please notify the **MRI techs** by **call or text** that you have arrived. Please do not email.

* Please use the hyperlinks in the workflow to direct you through the document.

Register as a PI

1. Navigate to the core page:
https://johnshopkins.corefacilities.org/service_center/show_external/5632/mri_service_center
2. Use your JHED credential and password to sign into iLab
3. If you have no other lab members to add, STOP here. If you have other members to add to your group, click the “menu” button and click 'my groups'. Then select your lab to continue.
4. New membership requests will show at the top of the ‘Membership Requests & Cost Objects’ tab. Click “Approve” to accept a member into your lab.
5. To assign any Cost Objects to a member of your lab, find the member under “Manage Cost Objects” section below the “Membership Requests” section. Select the checkbox(es) to the right of their name for the Cost Object(s) you wish to assign them. **You must assign at least one Cost Object to the lab member(s) who will make scanner reservations.**
6. Under the “Members” panel, you can set the auto-approval amount if you do not wish to approve service requests below a certain dollar amount.



Register as a lab member

1. Navigate to the core page:
https://johnshopkins.corefacilities.org/service_center/show_external/5632/mri_service_center
2. Use your JHED credential and password to sign into iLab
3. Click the “menu” button and select 'my groups'.
4. Under “My group”, select “Request Group Access”.
5. Type Institute and PI's name:

Request Group Access

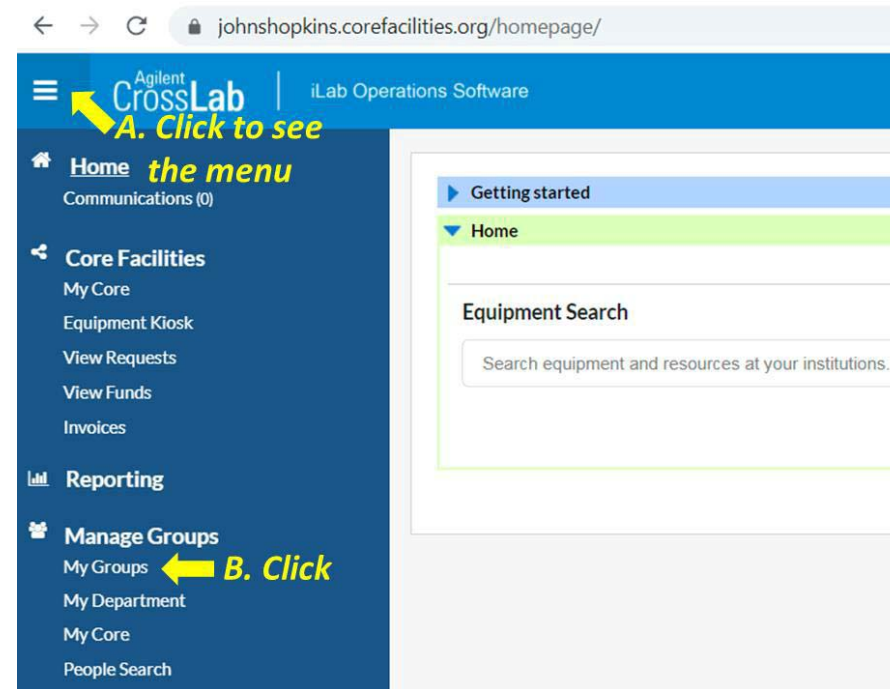
Institution *

Johns Hopkins University

Group *

Type PI's last name and select the correct PI

Please enter 2 or more characters

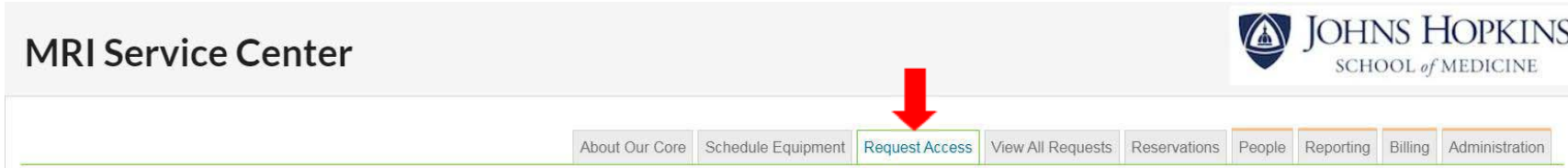


6. Click “Request Access”.

Your PI will receive a notification that you have requested membership to their lab in iLab. They will need to approve your membership and assign any Cost Objects for your use.

Submit an Access Request to MRI Service Center

1. Navigate to the core page:
https://johnshopkins.corefacilities.org/service_center/show_external/5632/mri_service_center
2. Enter your JHED credential and password, and sign in.
3. Select the “Request Access”



4. Click on the “request service” button

Request for access to MRI scanners


Please initiate this request to gain access to the scheduling system of our MRI scanners.



5. Complete the form and click on “submit request to researcher” at the lower-right bottom of the page once the form is finished.
6. Your request will be pending review by the MRI Service Center. The staff will review your request and either Agree to the work or will ask for more information if needed.

✓ submit request to researcher

MRI Service Center



About Our Core

Schedule Equipment

Request Access

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Billing

Administration

2. A calendar of the target scanner will open. On this calendar, click and drag on the time frame you would like to reserve.

3. A window will pop up that will allow you to adjust time and fill in the details of your reservation.

- Under “Required forms”, fields indicated by * must be filled.
- Times can be adjusted by clicking the pencil sign.
- If you need an MRI Tech to operate the scanner for you, you must check the “Reserve” box under "Reserve time on a linked schedule" and select an available MRI Tech (MRI Tech 1 or MRI Tech 2) to avoid double booking.
- Please check in the required field on your iLab reservation details page if contrast, or anesthesia machine is needed.
- Please make sure to input the protocol name that the MR Physicist assigned you.
- Payment information must be provided by selecting the Cost Object in the drop-down menu.

4. Once completed the form, click the “Save Reservation” button to finish.

MRI Screening Form

This form should be completed during the initial recruitment process. All the questions should be asked and answered in detail. This would include:

- A list of all surgeries, and **any implants**.
- If the patient has EVER worked with **metal**, cutting, grinding or pipe fitting, any accidents to the body, face or eyes with metal or glass.
- Does the patient wear a **glucose monitor or infusion pump**? These devices can be expensive and are not ok to go into an MRI environment. Scheduling around changing these devices will help avoid inconveniencing the patient.
- Does your patient needs **sedation** to help them through their scan?

If any of these or any of the other questions asked have a YES reply, they must be investigated at least 2 business days prior to the scheduled exam. This enables us to investigate any and all issues completely.

Please email MRI techs with any and all pertinent information. Please also be sure to have the pts Name, MRN and DOB on top of this form.

MRI Service Center

Accommodation Inquiry

Welcome to the MRI Service Center! To help us better accommodate your new study, please check all that apply.

Please select a Scanner:

- ☐ 3.0T Siemens Prisma
- ☐ 3.0T Phillips XMR
- ☐ 1.5T Siemens Espree

- ☐ My study will require a Radiologist report.
- ☐ My study will require an anesthesia machine
- ☐ My study will require the assistance of an MRI technologist
- ☐ My study includes contrast injection
- ☐ I will need a copy of the images after each appointment
 - ☐ I prefer a CD
 - ☐ I will provide a USB or hard drive for every appointment
- ☐ My study is a functional brain scan that requires use of a projector.

My study is expected to start in about mm/dd/yyyy: _____

My protocol name that was assigned by MR physicist: _____

Principle Investigator:

Phone #

Research Coordinator

Phone #

MRI Service Center

De-Identification form

This form helps us make sure your images do not have unwanted information on them. Please be sure to print and fill out this form for each patient if your study requires de-identified images. If your patient is receiving a Radiologist report, we will change the patient's information to what you provide on this form before uploading images to a CD or drive. If your patient is not receiving a Radiologist report we will enter, into the scanner, the information you provide below.

The following are required fields to begin your patient's scan. Please keep in mind most of this information will appear on the images.

Patient name:

Patient ID:

Weight:

Height:

Date of Birth:

Provided Protocol name:



JOHNS HOPKINS

M E D I C I N E

JOHNS HOPKINS BAYVIEW MEDICAL CENTER



MRI SCREENING

MRI PATIENT SCREENING

Patient Identification Information

List all Allergies: _____ ☐ No Known Allergies

List all Surgeries: _____ ☐ No Known Surgeries

Programmable Shunt	<input type="checkbox"/> YES <input type="checkbox"/> NO	Cochlear Implant/Ear Implant	<input type="checkbox"/> YES <input type="checkbox"/> NO
Pacemaker/Internal Defibrillator	<input type="checkbox"/> YES <input type="checkbox"/> NO	Hearing Aid	<input type="checkbox"/> YES <input type="checkbox"/> NO
Stimulator/Wires	<input type="checkbox"/> YES <input type="checkbox"/> NO	Eye Implants/weights	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tissue Expander	<input type="checkbox"/> YES <input type="checkbox"/> NO	Tracheostomy	<input type="checkbox"/> YES <input type="checkbox"/> NO
Aneurysm Clips	<input type="checkbox"/> YES <input type="checkbox"/> NO	IUD	<input type="checkbox"/> YES <input type="checkbox"/> NO
Epidural/Swan Ganz catheter	<input type="checkbox"/> YES <input type="checkbox"/> NO	Penile Prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Blood Vessel Coil/Stent Placement	<input type="checkbox"/> YES <input type="checkbox"/> NO	Bullets, BBs, Pellets	<input type="checkbox"/> YES <input type="checkbox"/> NO
Insulin or Pain Infusion Pump	<input type="checkbox"/> YES <input type="checkbox"/> NO	Medication/Nicotine Patch	<input type="checkbox"/> YES <input type="checkbox"/> NO
Artificial Limb	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pediatrics only: Are you currently having a sickle cell crisis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
IVC Filter	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have a history of welding or metal fragments in eyes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Harrington Rods	<input type="checkbox"/> YES <input type="checkbox"/> NO	Other implanted metal, piercings, tattoos, or devices	<input type="checkbox"/> YES <input type="checkbox"/> NO
Renal Disease: CKD, AKI, Renal Transplant, Total Nephrectomy	<input type="checkbox"/> YES <input type="checkbox"/> NO	Endoscopy/Colonoscopy Procedure in the last 8 weeks	<input type="checkbox"/> YES <input type="checkbox"/> NO
Partial Nephrectomy, Single Kidney, Renal Ablation	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had an MRI for the same body part in the last 10 days	<input type="checkbox"/> YES <input type="checkbox"/> NO
On Dialysis	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are you Pregnant ?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Diabetes Mellitus	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Menstrual Period _____ <input type="checkbox"/> N/A	
Age _____ Weight (lbs): _____ Height: _____		History of Claustrophobia	<input type="checkbox"/> YES <input type="checkbox"/> NO

Part A Patient or Guardian

I attest that the above information is correct. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, for the MRI procedure that is about to be performed.

Signature of ☐ Patient ☐ Guardian: _____ Date: _____ Time: _____
Signature

Part B Provider

If patient is not alert and oriented the provider must complete and sign

I attest that the above information has been confirmed and is verified by: ☐ Patient's Family/Guardian ☐ Other

Signature of Provider completing this form: _____ Provider ID number: _____ Date: _____
Signature

Print Provider's Name: _____ Provider's Contact number: _____ Time: _____

Part C Radiologist

I attest and verify that there is NO metal in the imaged body part. Radiologist's Signature/ID number: _____ Date/Time: _____

THIS SPACE IS FOR DEPARTMENT USE ONLY

Orbits: ☐ YES ☐ NO

Patient Wanded Prior to entering Zone4 ☐ YES ☐ NO

Pt given ear plugs / headset ☐ YES ☐ NO

Initial Reviewed By: _____ Date: _____ Time: _____
Print Name Signature

Final Reviewed By: _____ Date: _____ Time: _____
Print Name Signature