Weill Cornell Imaging
NewYork-Presbyterian Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122
Please call if you have any questions

NURSING HOME QUESTIONNAIRE

The following section is to be completed by the patient's Nurse, Care Partner, or Physician and Faxed back to 646-962-0122.

Patient's Full Name: _____ **Date of Birth:** _____

Yes	No	
☐	☐	Is the patient cooperative, coherent, and responsive?
		If a translator is needed, list language: _____
☐	☐	Does the patient need continuous nursing care? Is a transport nurse needed?
☐	☐	Is the patient on a cardiac monitor or a ventilator?
☐	☐	Does the patient require oxygen for transport?
☐	☐	Does the patient have peripheral IV access? (min. 20g for MRA procedures).
☐	☐	Is the patient in Isolation? If yes, what type?_____
☐	☐	Does the patient have a history of an MRI contrast allergy? (If YES, pre-medication is required)
☐	☐	Has the patient had surgery to the site to be examined?
		If YES, when, and what surgery?_____
☐	☐	Has the patient had previous MRI, CT, or X-rays to the site to be examined?
		If YES, what, where, and when:_____
☐	☐	Has the patient had CT or Iodine contrast in the past?
		If YES, when? _____
☐	☐	Has the patient received gadolinium contrast in the past?
		If YES, when? _____
☐	☐	Does the patient have any metal or implanted devices in their body?
		If YES, what kind of implant and where? _____

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

_____	_____	_____
Patient/ Parent/ Guardian/ Other Signature	Date	Time
_____	_____	_____
MR Technologist/MR Assistant/Other Signature	Date	Time

IMPORTANT! Prior to transport to MRI, all metal must be removed! No jewelry, watches, dentures, eyeglasses, hearing aids! No valuables!

----------FOR MRI STAFF ONLY: To Be Filed in the Medical Record----------

CONTRAST ORDER/SIGNATURE
Contrast Type:_____ Injection Rate:_____Injection Amount: Creatinine/GFR screening waived by: MR Technologist/RN/MD Signature: Radiologist Signature: