

Policy Name: Advanced Imaging Modalities - SOMI
Policy Number: RAD 8.09
Title of Policy Owner: Campus Director & Dean of Academic Affairs - SOMI
Policy Type: RHEI/Shared Services BSMCON SCHS SOMI
Approved by: RHEI Leadership Team
Effective Date: 8/1/2023
Version: 2.0
Policy Status: Approved

I. Policy:

It is the policy of Bon Secours St. Mary's Hospital School of Medical Imaging (SOMI) to provide students an opportunity to explore advanced imaging modalities.

II. Purpose:

The purpose of this policy is to outline the process for students enrolled in SOMI to rotate through advanced imaging modalities.

III. Scope:

This policy applies to all SOMI students.

IV. Policy Details:

Students enrolled in the Radiologic Technology program are provided an opportunity for limited rotations through advanced imaging modalities during the 4th and 5th semesters of the program. All students will participate in a four-hour rotation through both Computed Tomography (CT) and Magnetic Resonance Imaging (MRI). Students are required to complete an MRI screening procedure prior to an MRI rotation, as outlined below.

In addition to CT and MRI, students are required to spend ~~a~~ four hours in **three** of the following areas of their choosing (dependent on clinical site availability):

- Interventional Radiography (IR)
- Cardiac Cath
- Ultrasound/Sonography
- Nuclear Medicine
- Radiation Therapy
- Mammography

Once the student has completed the initial four-hour rotations in CT, MRI, and the three areas of their choosing (listed above), they will have the opportunity for an additional rotation through one of those areas for a maximum of two weeks (6 clinical

days) during the fifth semester. Students are able to explore the advanced imaging area of interest provided they have completed all required mandatory and elective radiologic competency procedures set forth by the ARRT and completed all required clinical assignments by the end of the 4th semester. Students are also required to meet with the Program Coordinator Clinical Education Experience to confirm all requirements were met.

MRI Screening Procedure

Prior to an MRI rotation, students are required to complete the MRI screening procedure and obtain clearance.

1. Students are required to complete an MRI History and Screening Sheet twice while enrolled in the Radiologic Technology program. Once during Program Orientation and again in the 3rd semester during PRO 2103 class. Students are responsible for informing the Program Coordinator of Clinical Education Experience of any changes in their medical history.
2. A Registered MRI Technologist reviews the students MRI History and Screening Sheets for contraindications and/or clearance.
3. If a student indicates “yes” on any of the questions on the MRI History and Screening Sheet, a school representative will take necessary actions to complete the screening procedure. It may be necessary to consult a Radiologist to determine clearance.
4. If a Radiologist determines orbit radiographs are needed, students will complete the Clearance Release Form.
5. The Radiologist will then provide final clearance.

V. Definitions:

None

VI. Attachments:

MRI History and Screening Sheet
Clearance Release Form

VII. Related Policies:

None

VIII. Disclaimers:

Nothing in this policy creates a contractual relationship between Bon Secours St. Mary's Hospital School of Medical Imaging (SOMI) and any party. SOMI, in its sole discretions, reserves the right to amend, terminate or discontinue this policy at any time, with or without advance notice.

IX. Version Control:

Version	Date	Description	Prepared by
1.0	5/20/2022	Initial Policy	Program Coordinator Clinical Education Experience
2.0	2/22/2023	New Template & Revisions	Program Coordinator Clinical Education Experience



Clearance Release Form

All students must complete the MRI History and Screening Sheet in preparation for a clinical rotation in MRI.

Students who indicate on page one of the MRI History and Screening sheet, a possibility of metal in their eye(s), will need to have radiographic images of the orbits performed to be eligible to participate in clinic.

Those students must complete the following steps of the clearance process:

1. Meet with the Emily Setelin, Medical Imaging Instructor to obtain instructions.
2. Register as a patient with Patient Registration at Bon Secours St. Mary's Hospital -Outpatient department for 2V radiographs of the orbits.
3. Dr. Somerville is the ordering physician.
4. Dr. Somerville will read images and dictate a report (fees to be waived).
5. Student is cleared or not cleared for MRI clinical rotation based on radiographic findings.

By signing below, I agree to follow procedure outlined above and I also agree for the School to obtain the results of cleared or not cleared.

Student Signature: _____

Rev. 5/2022



**BON SECOURS
RICHMOND HEALTH SYSTEM**
Bon Secours Richmond Health System

- Memorial Regional Medical Center
- Richmond Community Hospital
- St. Francis Medical Center
- St. Mary's Hospital
- Bon Secours Health Source
- Reynolds Crossing Imaging Center
- Midlothian Imaging Center
- Watkins Imaging Center

Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

Weight: _____ Height: _____

Referring Physician: _____

MRI HISTORY AND SCREENING SHEET

The following items can interfere with the images and some may be hazardous to your safety. Please indicate if you have any of the following:

- | | Yes | No |
|--|--------------------------|--------------------------|
| Brain surgery (of any kind) | <input type="checkbox"/> | <input type="checkbox"/> |
| Intracranial Pressure bolt..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Aneurysm surgery..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever, in your lifetime, worked around metal or performed metal grinding or welding (including auto body work)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any eye injuries involving metal | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear or eye surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| Body piercing..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing aids..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any removable dental work | <input type="checkbox"/> | <input type="checkbox"/> |
| Permanent eye liner or tattoos..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures or epilepsy | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal or ventricular shunt..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurostimulators (TENS unit), Spinal cord stimulator.... | <input type="checkbox"/> | <input type="checkbox"/> |
| Vascular access port..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Greenfield filter, inferior vena cava filter | <input type="checkbox"/> | <input type="checkbox"/> |
| Intravascular coil, filter, stent | <input type="checkbox"/> | <input type="checkbox"/> |
| Implanted cardiac defibrillator..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Internal electrodes including pacing/stimulator wires | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac pacemaker..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart valve replacement..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart bypass surgery..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Renal (kidney) or liver disease..... | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Yes | No |
|--|--------------------------|--------------------------|
| Breast implant/tissue expander..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnant, suspected pregnancy or breast feeding | <input type="checkbox"/> | <input type="checkbox"/> |
| IUD, diaphragm or pessary | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation seeds (e.g. cancer pt)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Penile prosthesis or other type of prosthesis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| History of being wounded by bullets, shrapnel, etc. | <input type="checkbox"/> | <input type="checkbox"/> |
| Ingested camera pill for endoscopy or endoscopic clips | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgical staples, clips or metallic sutures | <input type="checkbox"/> | <input type="checkbox"/> |
| Metal plates, pins, screws, wires or mesh implants..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of electronic, mechanical, or magnetic implant. | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of implant held in place by a magnet..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken the medication Feraheme (Ferumoxytol)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication patch | <input type="checkbox"/> | <input type="checkbox"/> |
| Implanted medication pumps | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin/infusion pump..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Antimicrobial wound or burn dressing | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you claustrophobic? (afraid of small places)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Prior history of chemotherapy, radiation therapy or cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertension (high blood pressure)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorders including diabetes or anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had an MRI before?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Please list any surgeries that you have had:

Please list any allergies or reactions you have to any medications, latex, or adhesives:

- Yes No
- INPATIENTS ONLY: SEND MAR WITH PATIENTS**
- | | Yes | No |
|---|--------------------------|--------------------------|
| Endotracheal tube | <input type="checkbox"/> | <input type="checkbox"/> |
| Swan-Ganz Catheter..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Extraventricular device..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Arterial line transducer | <input type="checkbox"/> | <input type="checkbox"/> |
| Foley catheter with temperature sensor and/or metal clamp | <input type="checkbox"/> | <input type="checkbox"/> |
| Rectal probe | <input type="checkbox"/> | <input type="checkbox"/> |
| Esophageal probe | <input type="checkbox"/> | <input type="checkbox"/> |
| Tracheotomy tube..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Guidewires..... | <input type="checkbox"/> | <input type="checkbox"/> |
| I.V. continuous drips | <input type="checkbox"/> | <input type="checkbox"/> |
| MAR on Chart..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Screening sheet faxed to MRI..... | <input type="checkbox"/> | <input type="checkbox"/> |



Place patient label inside box (if no patient label, complete below)

Name: _____

DOB: _____

MR #: _____

MRI HISTORY AND SCREENING SHEET (cont.)

Reason for today's test: (Please indicate any symptoms you have and the exact location of any pain/numbness)

PREVIOUS STUDIES YOU HAVE HAD RELATED TO TODAY'S PROBLEM:

Body Part/Type of Exam	Where performed	Date
_____	_____	_____
_____	_____	_____

MR-Gadolinium Contrast Media Information

Gadolinium is the key component of the contrast material most often given for Magnetic Resonance Exams. The intravenous use of Gadolinium improves image quality of the MRI and makes certain diseases easier to diagnose. Gadolinium is less likely to cause an allergic reaction, than the iodine based contrast given for computed tomography exams. Very rarely, patients are allergic to the Gadolinium based contrast materials and may experience hives, itchy eyes or skin, or nausea. These types of reactions are usually mild and are easily controlled with medications. It is extremely rare to have a severe reaction to Gadolinium.

Patients with kidney disease could experience a condition called Nephrogenic Systemic Fibrosis (NSF), which is a thickening of the skin and other organs. Although this is a rare complication, NSF can be life threatening. Gadolinium, typically is not given to those patients with severe kidney disease, although there may be rare exceptions at the discretion of the patient's physician. After your procedure has been completed, we recommend that you increase your fluid intake to help flush the contrast from your body.

The potential risks and benefits of Gadolinium have been explained to me. I understand that I may ask to speak with a physician before signing this form. My questions have been answered to my satisfaction.

I, _____, (printed name) agree to receive Gadolinium for my procedure if deemed necessary by my physician or the radiologist. I also attest that all of the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo. I understand that possible injury could result if I withhold vital information.

Person completing form: Patient Relative: _____ Nurse MRI Tech Other: _____

Print Name: _____ Signature: _____ Date: _____ Time: _____

This form will be scanned into your medical records

TO BE COMPLETED IN MRI

All information was reviewed by: MRI Tech MRI Nurse Radiologist Other _____

Print Name: _____ Signature: _____ Date: _____ Time: _____

Scanning Technologist: _____

Personal belongings removed _____ Returned

Print Name: _____ Signature: _____ Date: _____ Time: _____