CUH Emergency Department/ MRI – Scaphoid Injury Pathway

This pathway outlines flagging, protocolling and scheduling of MRI Scaphoid referrals from Dr Eanna McSuibhne (EM Consultant) to be scheduled in Mahon MRI Department as outpatients.

1. Dr. Eanna McSuibhne (or EM Consultant) will refer MRI Scaphoid examinations through ICM, following the assessment outlined in the 'Scaphoid Fracture Document'. '**Scaphoid Injury Pathway'** should be stated in the referral to identify patients to be booked using this pathway.

2. Dr Eanna McSuibhne (or a member of his team) will email CUH.MRI@hse.ie & colin.buckley@alliancemedical.ie to flag these patients.

3. Patients should be screened by referrer using the questionnaire in appendix 1 to ensure implants are flagged before scheduling appointment

4. The referring team will inform the patient directly that the scan will be performed in Mahon and can be sent home to await a phone call regarding scheduling within 5 working days.

   NB - Please be aware this pathway is not valid for scanning in CUH and if the patient declines to be scanned in Mahon, they will be added to outpatient waiting list for CUH which is not within the scope of this pathway)

5. Once MRI protocol the exam, the CUH Admin team will change the filter to 'MRI To Mahon'.

6. The Mahon MRI Department will book the patients within 5 working days of the referral.

Reporting

All MRI referrals through this pathway will be reported by CUH Radiology. The turnaround for reporting will be in line with outpatient reporting times.

Referral

Dr Eanna McSuibhne (EM Consultant) or another EM Consultant to refer – to state '**Scaphoid Injury Pathway'** on referral and clinical information

Vetting

MRI Radiographer – Protocol and add comment **'Scaphoid Injury Pathway'** for Mahon to identify for booking within 5 working days.

Scheduling

Mahon MRI Department – to schedule appointment within 5 working days of referral

Volume

X2 referrals per week

Exclusion Criteria

- Hoist Transfers
- Patients with active implants in situ that cannot be accommodated off site e.g. pacemakers, neurostimulators. programmable shunts etc. (ensure screening at point of referral is performed)
- Any MRI Referral other than 'MRI Scaphoid'

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Appendix 1

Alliance Medical

MRI Questionnaire

Patient ID:

Name:

Date of Birth:

Sex: Male ☐ Female ☐ Non-Binary ☐

Address:

Preferred Pronouns:

Height: **Weight:**

MRI involves taking pictures of the body using a strong magnetic field. For your safety it is important that you read and answer the questions below carefully. Please notify staff if you answer YES to any of the following.

Patient History	YES	NO	*Staff Use Only*
1. Do you have or have you ever had a cardiac pacemaker or defibrillator?	☐	☐	
2. Have you ever had heart surgery (e.g., heart valve replacement/bypass)?	☐	☐	
3. Have you ever had head surgery (e.g., aneurysm clip/shunt/septal button)?	☐	☐	
4. Have you had any surgery in the last 3 months or to the area being scanned?	☐	☐	
5. Do you have any clips/pins/screws/staples/joint replacements/implants/artificial limbs?	☐	☐	
6. Do you have an eye or ear implant (e.g., cochlear implant/hearing aid/false eye)?	☐	☐	
7. Do you have any coils, filters, stents, meshes or shunts inside of your body?	☐	☐	
8. Do you have or have you ever had any electronically/mechanically activated implant or drug/infusion pump (e.g., nerve stimulator/baclofen pump)?	☐	☐	
9. Have you ever had a capsule endoscopy (PillCam/MiroCam/Olympus/OMOM)?	☐	☐	
10. Are you wearing a medicated skin patch or silver dressing or glucose monitor?	☐	☐	
11. Have you ever had a gunshot or shrapnel injury?	☐	☐	
12. Have you had any tattoos in past 48 hours?	☐	☐	
13. Do you currently have any body piercings, dentures, dental plates or braces?	☐	☐	
14. Do you suffer from dizzy spells, falls, seizures, blackouts or epilepsy?	☐	☐	
15. Have you ever worked welding/cutting metal/grinding metal?	☐	☐	
16. If you worked with metal, did you always wear eye protection?	☐	☐	
17. Have you ever had an eye injury or had metal fragments in your eyes?	☐	☐	
18. Recently - have you had any imaging of the area being scanned?	☐	☐	

19. Have you had an injection of contrast agent before?	☐	☐	
20. Have you ever had a reaction to any contrast agent (dye)?	☐	☐	
21. Do you have any allergies, hay fever or asthma?	☐	☐	
22. Are you diabetic or do you have known kidney failure?	☐	☐	
23. Have you had or are you waiting for a liver transplant?	☐	☐	

24. Do you have a contraceptive implant or coil?	☐	☐	
25. Is there any possibility that you may be pregnant?	☐	☐	
26. Sex to which you were assigned at birth:	Male ☐ Female ☐		
27. What was the first day of your last menstrual period?	Date:		

▪ I have removed all metal objects from my person	☐
▪ I can confirm that I have answered these questions correctly to the best of my knowledge	☐
▪ I consent to an injection of contrast agent for this examination if required	☐

Patient/Guardian Signature:	**Date:**	**Time:**
Screening Radiographer Signature:	**Date:**	**Time:**

NB: For patients under 16 a parent or guardian must sign the questionnaire on the patient's behalf witnessed by a Radiographer

Scanning Radiographer Initials:	*Correct Patient on Modality:*	*Correct side & site:*