Registration and Inventory of Medical Equipment

Mobile Magnetic Resonance Imaging Scanners
January 2024

Instructions
This is the legally required "Registration and Inventory of Medical Equipment" (G.S. 131E-177) for mobile magnetic resonance imaging (MRI) scanners. Please complete all sections of this form and return to Healthcare Planning by **Friday, January 26, 2024**.

1. **Submit one completed Registration and Inventory form per MRI scanner.**
2. Complete and sign the form
3. Return the form by one of two methods:
   a. Email a scanned copy to DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.
   b. Mail the form to Andrea Emanuel, Healthcare Planning, 2704 Mail Service Center, Raleigh, NC 27699-2704.

If you have questions, call Andrea Emanuel in Healthcare Planning at (919) 855-3954 or email DHSR.SMFP.Registration-Inventory@dhhs.nc.gov.

Section 1: Contact Information

1. Full legal name of corporation, partnership, individual, or other legal entity that acquired the equipment by purchase, donation, lease, transfer, or comparable arrangement:

   ____
   (Legal Name)

2. Address of the corporation, partnership, individual, or other legal entity that acquired the equipment:

   ____
   (Street and Number)

   ______________________________ (____) ______________
   (City) (State) (Zip) (Phone Number)

3. Chief Executive Officer or approved designee who is certifying the information in this registration form:

   ____
   (Name) (Title)

   ____
   (Street and Number) (City) (State) (Zip)

   (____) ______________ ______________________________
   (Phone Number) (Email)

4. Information compiled or prepared by: ______________________________
   (Name)

   (____) ______________ ______________________________
   (Phone Number) (Email)

Section 2: Equipment and Procedures Information

Reporting Period: ☐ 10/01/2022 – 9/30/2023 ☐ Other time period: ____________________

Do not make extra copies of this page if the entity has multiple MRIs. Submit a complete, separate R&I form for each scanner.

(Please make additional copies of this page as needed for additional Service Sites.)

For DHSR Planning Use Only:	
Manufacturer/Tesla	/
Model number	
Open or closed (including open bore) scanner	☐ Open ☐ Closed
Serial or I.D. Number	
Date of acquisition	
Purchase price (if purchased)	
Certificate of Need Project ID (or Legacy)	☐ Legacy
Certificate holder, as listed on Certificate of Need	
If equipment went to only 1 site, is it permanently parked at that site?	☐ Parked ☐ Not Parked
	Service Site Number _____
Service Site Information: Please include **all** the information requested for each location.	Service Site ____________________ Address ____________________ City: ____________ Zip_______ County ____________
Procedures*: - with Contrast or Sedation - without Contrast/ Sedation -Total inpatient/outpatient **Total Number of Procedures**	**Inpatient:** with: _________ w/out: _________ Total: _________ **Outpatient:** with: _________ w/out: _________ Total: _________ **Total**: ___________
For each day of the week, enter the **number of hours** the scanner is in operation.	___ Sunday ___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday ___ Saturday
Total number of hours in operation for reporting period	

*An **MRI procedure** is defined as a single discrete MRI study of one patient (single CPT coded procedure). An MRI study means one or more scans relative to a single diagnosis or symptom. **The total number of procedures should be equal to or greater than the total number of patients reported on the MRI Patient Origin Table on page 3 of this form.**

Name of entity that acquired the equipment (from page 1) ______________________________

Section 3: Patient Origin Data by Service Site

Please provide the county of residence for each patient who received MRI services during the time period of this report. Provide patient origin data separately for each service site. Make additional copies of this page as needed. The total number of patients receiving services should be equal to or less than the total number of procedures reported on page two of this form.

Service Site Number: ____

Service Site Name: ____

County in which service was provided: ____

Patient County	Number of Patients	Patient County	Number of Patients	Patient County	Number of Patients
1. Alamance		37. Gates		73. Person	
2. Alexander		38. Graham		74. Pitt	
3. Alleghany		39. Granville		75. Polk	
4. Anson		40. Greene		76. Randolph	
5. Ashe		41. Guilford		77. Richmond	
6. Avery		42. Halifax		78. Robeson	
7. Beaufort		43. Harnett		79. Rockingham	
8. Bertie		44. Haywood		80. Rowan	
9. Bladen		45. Henderson		81. Rutherford	
10. Brunswick		46. Hertford		82. Sampson	
11. Buncombe		47. Hoke		83. Scotland	
12. Burke		48. Hyde		84. Stanly	
13. Cabarrus		49. Iredell		85. Stokes	
14. Caldwell		50. Jackson		86. Surry	
15. Camden		51. Johnston		87. Swain	
16. Carteret		52. Jones		88. Transylvania	
17. Caswell		53. Lee		89. Tyrrell	
18. Catawba		54. Lenoir		90. Union	
19. Chatham		55. Lincoln		91. Vance	
20. Cherokee		56. Macon		92. Wake	
21. Chowan		57. Madison		93. Warren	
22. Clay		58. Martin		94. Washington	
23. Cleveland		59. McDowell		95. Watauga	
24. Columbus		60. Mecklenburg		96. Wayne	
25. Craven		61. Mitchell		97. Wilkes	
26. Cumberland		62. Montgomery		98. Wilson	
27. Currituck		63. Moore		99. Yadkin	
28. Dare		64. Nash		100. Yancey	
29. Davidson		65. New Hanover			
30. Davie		66. Northampton		101. Georgia	
31. Duplin		67. Onslow		102. South Carolina	
32. Durham		68. Orange		103. Tennessee	
33. Edgecombe		69. Pamlico		104. Virginia	
34. Forsyth		70. Pasquotank		105. Other (specify)	
35. Franklin		71. Pender			
36. Gaston		72. Perquimans		**Total Number of Patients**	

Name of entity that acquired the equipment (from page 1) _______________________________________

Section 4: Certification and Signature

The undersigned Chief Executive Officer or approved designee certifies the accuracy of the information contained on all pages of this form.

Signature ____

Print Name ____

Date signed ____

Note: Healthcare Planning and Certificate of Need may request CPT codes for MRI procedures if further clarification is needed.

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