Open Multi-Positional MRI SCREENING SHEET

Patient Name:_______________________________ Date:________________ Appointment Date:____________________

DOB:____________________ Referring Physician:____________________________

Phone:____________________ Is this your first MRI:___________ Date of Prior MRI:_______________________

Weight:____________________ Are you using a walker, wheelchair or cane?:___________

Do you have any of the following:

Pacemaker	□ Yes	□ No
Implanted Cardiac Defibrillator	□ Yes	□ No
Imbedded bullets or BB Pellets	□ Yes	□ No
Metal Shrapnel (metal fragments)	□ Yes	□ No
Body Piercing/Bobby pins or hair clips	□ Yes	□ No

Implants of any kind	□ Yes	□ No
Dentures or Partials	□ Yes	□ No
Infusion Pumps	□ Yes	□ No
Heart Valve	□ Yes	□ No
Artifical limbs	□ Yes	□ No
Hearing Aid	□ Yes	□ No
Tattoo or tattooed eye liner/brow	□ Yes	□ No
Cardiac Stent	□ Yes	□ No
Aneursym Clips (BRAIN)	□ Yes	□ No
Cochlear Ear Implants	□ Yes	□ No
Transdermal Patch (NicoDerm patch)	□ Yes	□ No
Retinal Tack (EYE SURGERY)	□ Yes	□ No
Magnetic Dental implants	□ Yes	□ No
Electrical/Nerve/Spine Stimulators	□ Yes	□ No

Contrast Screening

Please select all that apply:

- □ Renal (KIDNEY) Disease
- □ Age 60 or older
- □ Hypertension (high blood pressure)
- □ Diabetes
- □ Severe liver disease, liver transplant, pending liver transplant
- □ History of past low back surgery

** Please note that if an exam is ordered with contrast, all LABS need to be drawn within 24 hrs before exam

Arthrogram Screening

□ Yes □ No Allergy to Iodine?

□ Yes □ No Do you require the use of oxygen?

If yes, you will need to bring 50 ft. of soft tubing with connector

□ Yes □ No Have you ever worked in a metal or machine shop?

□ Yes □ No Have you ever been struck in the eyes with metal shavings?

If YES, you may require screening x-ray of orbits

□ Yes □ No Any type of metal rods, pins, screws, nails, plates, wires, or mesh?

□ Yes □ No Coils, Catheters, Filters, Wires or shunts in blood vessels

If you answered YES to any of these questions, please call Hampton Roads Orthopaedics & Sports Medicine at (757) 926-4351 prior to your appointment.

Have you ever had:

Cranial surgery (HEAD/BRAIN)	□ Yes	□ No	If YES, please explain:____________________
Neck surgery	□ Yes	□ No	If YES, please explain:____________________
Chest surgery	□ Yes	□ No	If YES, please explain:____________________
Arthroscopic surgery	□ Yes	□ No	If YES, please explain:____________________
Any other surgery	□ Yes	□ No	If YES, please explain:____________________
Do you have any allergies	□ Yes	□ No	If YES, please explain:____________________
History of cancer or tumors	□ Yes	□ No	If YES, please explain:____________________
Have you had radiation therapy?	□ Yes	□ No	If YES, please explain:____________________
Chemotherapy?	□ Yes	□ No	If YES, please explain:____________________

FEMALES

Date of last menstual cycle:______________

Are you or could you be pregnant:__________

Intrauterine Device/Pessary present?________

Are you nursing?:____________________

I verify that the answers I have provided to questions in this form are correct and I understand that withholding information or inaccurate information may adversely affect the interpretation of this exam or could lead to injury or death.

Patient's Signature:_____________________________________ Date:____________________

NO-SHOW POLICY: In the event that I do not show up for my scheduled appointment, I understand that I will be charged a $75.00 fee which must be paid prior to rescheduling the appointment.

Patient's Signature:_____________________________________ Date:____________________

Technologist comments: ____

Technologist initials: ______________

Additional notes: ____

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Follow-Up Appointment Date:_______________________