Open Multi-Positional MRI SCREENING SHEET

Patient Name:_____ Date:_____ Appointment Date:_____

Phone:_____ DOB:_____ Weight:_____ Referring Physician:_____

Is this your first MRI?:_____ Are you using a walker, wheelchair or cane?:_____

If no, what is the date and location of your prior MRI?:_____

PLEASE MAKE SURE TO ANSWER ALL QUESTIONS BELOW

Do you have any of the following?

Pacemaker	□ Yes	□ No
Implanted Cardiac Defibrillator	□ Yes	□ No
Imbedded bullets, BB Pellets, Shrapnel	□ Yes	□ No
Brain Surgery	□ Yes	□ No
Aneurysm Clips/Coils in Brain	□ Yes	□ No
Body Piercing/Bobby pins or hair clips	□ Yes	□ No
Dentures or Partials	□ Yes	□ No
Infusion Pumps	□ Yes	□ No
Artificial Limbs	□ Yes	□ No
Tattoo or tattooed eye liner/brow	□ Yes	□ No
Transdermal Patch (NicoDerm patch)	□ Yes	□ No
Hearing Aid	□ Yes	□ No
Electrical/Nerve/Spine Stimulators	□ Yes	□ No
History of cancer or tumors	□ Yes	□ No
Have you had radiation therapy	□ Yes	□ No
Chemotherapy	□ Yes	□ No

Contrast Screening

Please select all that apply:

Renal (KIDNEY) disease	□ Yes	□ No
Age 60 or older	□ Yes	□ No
Hypertension (High blood pressure)	□ Yes	□ No
History of diabetes	□ Yes	□ No
Severe liver disease, liver transplant	□ Yes	□ No
History of past low back surgery	□ Yes	□ No
Any allergies_____	□ Yes	□ No

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

Arthrogram Screening

Are you allergic to IODINE? □ Yes □ No

Females

Are you or could you be pregnant? □ Yes □ No

Are you nursing?: □ Yes □ No

Do you require the use of oxygen? *If yes, you will need to bring 50 feet of soft tubing with connector* □ Yes □ No

Have you ever been struck in the eyes with metal shavings? *If yes, you may require an orbital x-ray* □ Yes □ No

IMPLANTS AND SURGICAL HISTORY

Do you have anything implanted in your body that you were not born with? □ Yes □ No

If yes, WHAT?_____and WHERE?_____

Have you had any surgery on the following:	Ears	□ Yes	□ No	*If yes, what type?:*_____
	Eyes	□ Yes	□ No	*If yes, what type?:*_____
	Heart	□ Yes	□ No	*If yes, what type?:*_____
Do you have a STENT?		□ Yes	□ No	(please make copy of card)
Do you have a HEART VALVE?		□ Yes	□ No	(please make copy of card)

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

Patient Signature:_____ Date:_____

MRI CANCELLATION POLICY

If you arrive more than 15 minutes late for your appointment without prior notification, we may reschedule your appointment and you may be considered a no-show. After 3 cancellations and/or no shows you will be scheduled for your MRI at another facility. We reserve the right to charge a fee of $75 for failure to cancel or reschedule your appointment within 24 hours of your scheduled appointment time.

Patient Signature:_____ Date:_____