

Open Multi-Positional MRI SCREENING SHEET

Date: _____

Patient Name: _____ Phone: _____ DOB: _____ Weight: _____

Referring Physician: _____

Yes / No Is this your first MRI? If **NO**, what is the date and location of your prior MRI? _____

Yes / No Are you using a walker, wheelchair or cane? If **YES**, can you bear your own weight briefly without assistance? **Yes / No**

PLEASE MAKE SURE TO ANSWER ALL QUESTIONS BELOW

Do you have any of the following?

Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implanted Cardiac Defibrillator	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Imbedded bullets, BB Pellets, Shrapnel	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Brain Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aneurysm Clips/Coils in Brain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Body Piercing/Bobby pins or hair clips Yes No

Dentures or Partials Yes No

Infusion Pumps Yes No

Prosthetic Limbs (not including replacements) 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

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

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

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

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

Please note that HROSM reserves the right to cancel or reschedule your appointment if you arrive 15 minutes late to your scheduled appointment without prior notification. Should you need to cancel or reschedule your appointment, please contact our office within 24 hours of your scheduled scan. If you cancel or reschedule within the specified 24 hour period, you will not be charged a cancellation fee. HROSM reserves the right to charge a \$50.00 cancellation fee and may not reschedule your appointment at our facility.

Patient Signature: _____ Date: _____