

MRI PATIENT SCREENING FORM

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Ht: _____ Wt: _____

Ordering Physician: _____ Procedure: _____

IMPORTANT INSTRUCTIONS:

Before entering the MRI area, you must remove all metallic objects including hearing aids, dentures, false teeth, partial dental plates, eyeglasses, jewelry (e.g. necklaces, pins, rings, watch, etc.), hair pins (bobby pins, barrettes, clips, etc.), pagers, cell phones, credit and bank cards and all other cards with a magnetic strip, and any body piercing objects.

NOTE: You may be advised to wear ear plugs or to use headphones that we supply during the MR examination. Since, some patients may find the noise levels unacceptable.

PATIENT HISTORY

	YES	NO			YES	NO	
			Cardiac pacemaker – if Yes, DO NOT PROCEED with exam				Stent, coil, filter or shunt (spinal or intraventricular)
			Aneurysm clip(s)				Any type of prostheses (e.g. eye, penile, etc.)
			Claustrophobia				Joint replacement (hip, knee, shoulder, etc)
			Implanted cardiac defibrillator (ICD)				Vascular access port and/or catheter
			Implanted drug pump(e.g. insulin, chemotherapy, pain medication)				Patch-type drug infusion device (e.g. pain patch, hormone replacement, nicotine, etc.)
			Swan-Ganz or thermo-dilution catheter				Artificial heart valve
			Electronic, mechanical or magnetic implant device				Metallic fragment of foreign body (e.g. shrapnel, bullet, BB)
			Internal electrodes or wires(e.g. pacing)				Magnetically -activated implant or device
			Bone growth/bone fusion stimulator				Surgical clips, staples or metallic sutures
			Cochlear, otologic or other ear implants				Artificial limb or joint
			Neurostimulator				Bone/joint pins, screw, nail, wire, plate, etc.
			Any Biostimulator: Type: _____				Tissue expander or implants (e.g. breast, hair etc.)
			Arterial line transducer				Tattoos or permanent make-up, piercings

YES NO Have you ever had an MRI before? If yes, when _____

YES NO Did you have any problems? If yes, please describe _____

YES NO Are you able to lie flat and still?

YES NO Have you had a surgical operation/procedure of any kind? If yes, please list with approximate dates:

YES NO Have you ever been exposed to metal fragments (metallic slivers/shavings, foreign objects) that can be lodged in your eyes or body? If yes, please describe _____

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CONTRAST HISTORY

- YES NO Do you have any allergies (medication, food, latex, etc.)? If yes, please list _____
- YES NO Have you ever received a contrast agent or x-ray dye used for MRI, CT or other x-ray studies?
- YES NO Have you ever had a reaction to a contrast agent used for MRI or CT? If yes, please describe _____
- YES NO Do you have a history of renal disease, seizures, asthma, allergic respiratory disease or liver disease?
- YES NO Do you have anemia or disease that affect the blood? Please list: _____
- YES NO Do you have diabetes? If yes, are you taking any of the following?
- Glucophage Glyburide Glucovane Other: _____

FEMALE PATIENTS ONLY

- Date of last menstrual period: _____ Post-menstrual? YES NO
- YES NO Are you pregnant or suspect you may be pregnant?
- YES NO Are you breastfeeding?
- YES NO Diaphragm, IUD, Pessary? Other types of birth control: _____

AFFILIATED RADIOLOGISTS' AUTHORIZATION

I hereby authorize Midwest Orthopaedics, its physicians, nurses, employees or agents to furnish to any representative, agent or employee, nurse or physician of Affiliated Radiologists, S.C. any and all records, reports and information including but not limited to any and all medical records, diagnostic imaging studies, consultation reports, discharge summaries, histories and physical examinations, operative reports, laboratory reports, x-ray reports, nurses' notes, demographic information and any billing or insurance information needed to interpret my diagnostic imaging studies; to determine any and all diagnosis, treatment or prognosis; and to facilitate the billing by Affiliated Radiologist for its professional services.

Upon presentation of this authorization or an exact photocopy thereof, which shall be considered as valid as the original, Midwest Orthopaedics is directed to permit the personal review, copying or photocopying of all such records, reports, information and diagnostic imaging studies by a representative of Affiliated Radiologists, S.C. This authorization expressly waives any requirements that it must be used within a certain amount of days or within any period after the date hereof. I reserve the right to revoke this authorization at any time, but this will not apply to information already released.

In the event contrast material is injected, I understand that by consenting to the use of gadolinium, I may be receiving it for uses other than its FDA approved indication. I have had the risks and potential benefits explained to me. I have had an opportunity to ask questions and had all my questions answered to my satisfaction. I consent to the performance of an MRI and if applicable, consent to the administration of gadolinium during this exam. In addition, I attest that the above information is correct to the best of my knowledge. I have read and understood the entire content of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient/Guardian Signature: _____ **Date:** _____

Technologist Signature: _____ **Date:** _____

Printed Technologist Name: _____