

Name _____ Height _____ Weight _____

Birth Date _____ Age _____ Physician's name _____

Briefly describe the physical symptoms you are experiencing or the reason for the exam: _____

How long have you had this problem? _____

Have you had any previous studies: YES ___ NO ___ (If YES please list)

	BODY PART	DATE	FACILITY LOCATION
MRI	_____	_____	_____
CT/CAT SCAN	_____	_____	_____
X-RAY	_____	_____	_____

Are you pregnant or experiencing a late menstrual period? YES ___ NO ___

Date of last menstrual period _____ Are you breastfeeding YES ___ NO ___

Have you ever had a reaction to the contrast media or dye used for MRI'S OR CT'S examinations?
 YES ___ NO ___ If yes, please describe _____

Do you have a personal history of cancer? YES ___ NO ___
 If yes, what type of cancer was/ is it? _____

Have you been diagnosed, or are you being treated for any medical conditions or illnesses? YES ___ NO ___
 If yes, give a brief explanation: _____

YOUR DOCTOR WILL GET A COPY OF THE RESULTS WITHIN A FEW DAYS.

Normally the MRI scan is considered very safe. However, patients with certain implants and foreign bodies may have some problems. It is important for you to alert the technologist if there is any foreign material in your Body.

On some examinations it is necessary to inject a contrast material into your body. It is injected through an IV that may be placed in your arm or hand. Normally, this contrast media is very safe. However, any injection or medication carries with it risks. These risks may include problems from the IV or in the form of a reaction to the contrast. The Physicians and staff of the diagnostic imaging department are trained to treat these reactions. Do you consent to having the contrast injected if necessary? YES ___ NO ___

We are only able to scan the body part that your Doctor has ordered. Do you consent to having the ordered MRI scan, and to changing into metal free clothing before the exam? YES ___ NO ___

“PLEASE COMPLETE AND SIGN THE NEXT PAGE”

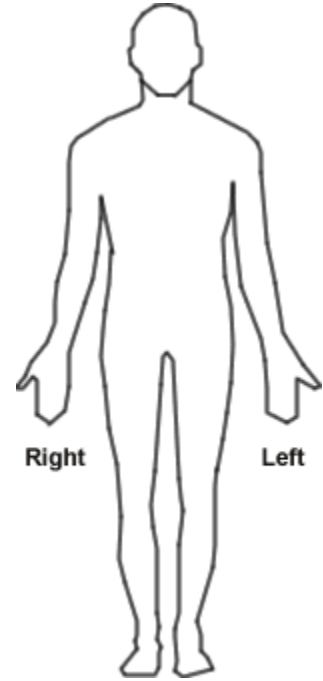
Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for the following.

Do you have any of the following?

- YES ___ NO ___ **CARDIAC PACEMAKER**
- YES ___ NO ___ **IMPLANTED CARDIAC DEFIBRILLATOR**
- YES ___ NO ___ **ANEURYSM CLIP(S)**
- YES ___ NO ___ **NEUROSTIMULATOR**
- YES ___ NO ___ **INSULIN OR INFUSION PUMP**
- YES ___ NO ___ **IMPLANTED DRUG INFUSION DEVICE**
- YES ___ NO ___ **BONE GROWTH/FUSION STIMULATOR**
- YES ___ NO ___ **COCHLEAR, OTOLOGIC, OR EAR IMPLANT**
- YES ___ NO ___ **ANY TYPE OF PROSTHESIS (EYE, PENILE, ETC)**
- YES ___ NO ___ **HEART VALVE PROSTHESIS**
- YES ___ NO ___ **ARTIFICIAL LIMB OR JOINT**
- YES ___ NO ___ **ELECTRODES (ON BODY, HEAD, OR BRAIN)**
- YES ___ NO ___ **INTRAVASCULAR STENTS, FILTERS, COILS**
- YES ___ NO ___ **SHUNT (SPINAL OR INTRAVENTRICULAR)**
- YES ___ NO ___ **VASCULAR ACCESS PORT AND/OR CATHETER**
- YES ___ NO ___ **SWAN-GANZ CATHETER**
- YES ___ NO ___ **ANY IMPLANT HELD IN PLACE BY A MAGNET**
- YES ___ NO ___ **TRANSDERMAL DELIVERY SYSTEM (NITRO)**
- YES ___ NO ___ **IUD OR DIAPHRAGM**
- YES ___ NO ___ **TATTOOED MAKEUP (EYELINER, LIPS, ETC.)**
- YES ___ NO ___ **BODY PIERCING(S)**
- YES ___ NO ___ **ANY METAL FRAGMENTS**
- YES ___ NO ___ **INTERNAL PACING WIRES**
- YES ___ NO ___ **AORTIC CLIP**
- YES ___ NO ___ **METAL OR WIRE MESH IMPLANTS**
- YES ___ NO ___ **WIRE SUTURES OR SURGICAL STAPLES**
- YES ___ NO ___ **HARRINGTON RODS (SPINE)**
- YES ___ NO ___ **METAL RODS IN BONES**
- YES ___ NO ___ **JOINT REPLACEMENT**
- YES ___ NO ___ **BONE/JOINT PIN, SCREW, NAIL, WIRE, PLATE**
- YES ___ NO ___ **HEARING AID (REMOVE BEFORE MRI)**
- YES ___ NO ___ **DENTURES (REMOVE BEFORE MRI)**
- YES ___ NO ___ **AN INJURY TO THE EYE INVOLVING A METALLIC OBJECT?**

OTHER, Please explain: _____

Please mark on the figure below, the location of any implant or metal inside of or on your body:



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, body piercing, bra, watch, safety pins, paperclips, money clips, credit cards, coins, pens, belt, metal buttons, pocketknife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE EXAM

Signature of Person completing Form _____ Date _____

Form completed by: PATIENT ___ RELATIVE: _____
Name & Relationship to patient

OTHER: _____
Name & Relationship to patient

(Please print)

1. PATIENT'S
NAME _____ DATE _____

2. REFERRING
PHYSICIAN _____

3. Have you had an MRI or CT on the part of your body in which the procedure is to be performed? YES _____ NO _____

4. At which facility was your MRI or CT performed?

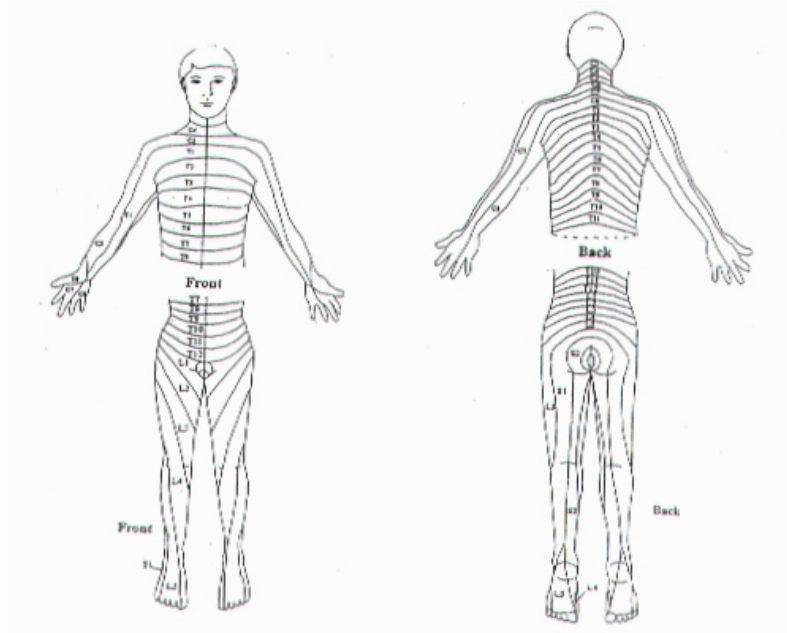
5. What is the level of intensity of your pain at this time on a scale of 0 to 10, with 0 being no pain and 10 being the greatest pain?

6. Have you had surgery on the part of your body being scanned today? YES _____
NO _____

7. If you did have surgery, how long ago was this surgery performed? _____

Describe the location of your pain _____

SHADE IN THE AREA OF PAIN, NUMBNESS, AND/OR TINGLING:



LEVEL OF PAIN AT DISCHARGE _____