IMAGING ASSOCIATES
Expert Radiology. Exceptional Care.

If you have any questions or concerns before you enter the MRI room, please consult the MRI technologist or radiologist. Additionally, please be aware that the MRI magnet is always on and for safety reasons you must remove all metallic objects, including hearing aids, dentures, partial plates, metallic body piercings, jewelry, keys, credit cards, eyeglasses, barrettes, watches, pens, belt buckles, hairpins, etc.

PATIENT HISTORY AND SCREENING FORM FOR MRI

Patient's Name: _____ Today's Date: _____

Weight: _____ Height: _____ DOB: _____ Age: _____ Sex: M F

Procedure: _____ Referring Physician: _____

Why are you having an MRI today? Please explain your medical problem in detail (what is the problem? Where is the problem? How long have you had this problem?): _____

_____

_____

Have you had a previous exam related to this problem? (Circle) Yes No

Have you taken any sedation/medication/alcohol today to relax you for this procedure?

(Circle) Yes No

If yes, what? _____

Please answer the RELEVANT questions in as much detail as possible

If you are having a ***BRAIN*** **MRI (circle appropriate answer)**:

Do you have a brain tumor?	Yes	No	Have you had significant head trauma?	Yes	No
Do you have seizures?	Yes	No	Do you have a history of Multiple Sclerosis?	Yes	No
If yes, since when? _____			Do you have a history of strokes?	Yes	No
Have you had brain Surgery?	Yes	No	Do you have a history of bleeding?	Yes	No

Please use this space for explanation: _____

If you are having a ***SPINE*** **MRI:**

Where is your back/neck pain? _____

Does the pain go down your arms or legs? _____

Do you have numbness? Yes No If yes, where? _____

Do you have weakness? Yes No If yes, where? _____

Have you had back/neck surgery? Yes No If yes, when? _____

If known, what level was your surgery? _____

If you are having a ***JOINT/MUSCULOSKELETAL*** **MRI:**

Has there been an injury? Yes No If yes, what type of injury? _____

Have you had prior surgery to this area? Yes No

Describe the location of symptoms in relation to the joint: _____

_____

MRI SAFETY INFORMATION

The following items can interfere with MR Imaging or potentially be a safety hazard in the scanner. Please indicate if you have, or have ever had, any of the following (circle):

History of Cancer:	Yes	No	Medication infusion pump	Yes	No
Pacemaker/Defibrillator:	Yes	No	Internal electrodes or wires:	Yes	No
Aneurysm clips:	Yes	No	Surgical clips:	Yes	No
Ear implants/hearing aid:	Yes	No	Biostimulator, Neurostimulator, Mechanical		
Metal implants:	Yes	No	or Magnetic implant:	Yes	No
Blood disorder or Sickle Cell	Yes	No	Denture plate or bridge:	Yes	No
Allergic respiratory Disease:	Yes	No	Stents, shunts, or coils:	Yes	No
Metal fragments:	Yes	No	Prosthetics:	Yes	No
Shrapnel, bullets or BB's	Yes	No	Foil lined medication patch:	Yes	No
Metal in or removed from eyes:	Yes	No	Tattoos or body piercings:	Yes	No
Kidney disease or Dialysis:	Yes	No	Penile implants:	Yes	No
Cardiac Loop Recorder:	Yes	No	Catheters:	Yes	No
Claustrophobia:	Yes	No	Breast tissue expanders:	Yes	No

Is there any possibility that you are, or may be, pregnant? Yes No

Last menstrual period: _____

Are you currently breastfeeding? Yes No

Diaphragm/IUD/Pessary Yes No

Explain any answers to "yes" above_____

_____

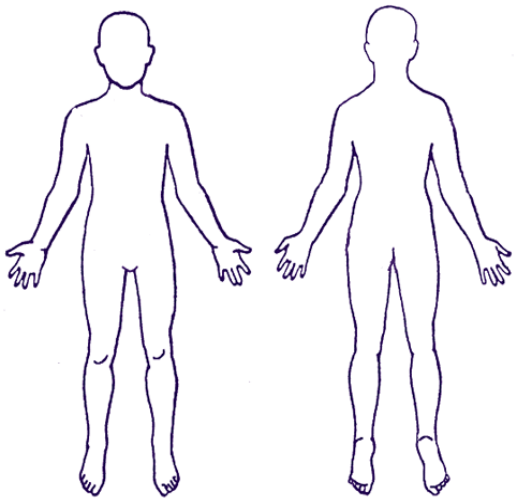
Acknowledgement:

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

_____ _____ _____

Patient/Parent/Legal Guardian Technologist/Witness Signature Date

Draw on the figures below where the pain or symptoms are located:



Clinical Use Only

Lab Results: Creatinine: _____ GFR: _____

_____mL of Gadavist Eovist

With a _____ (Ga & type) @ _____ (time)

_____ by _____

(# of punctures) (signature)

Location _____ Lot #_____

Exp. Date _____

Contrast reaction: Yes No

Explain: _____

Discharge instructions for contrast reaction given?

Yes N/A Form# _____

Discharge instructions for contrast extravasation given: Yes N/A Form#_____