

Date _____ / _____ / _____ Name _____ Birth Date _____

Last Name
First Name
M.I.

Height _____ Weight _____ Phone (Home) (_____) _____ (Work) (_____) _____

Physician's Name & Phone No. _____

Why has your physician scheduled this MRI scan? _____

1. Have you ever had surgery or any similar invasive procedure? No Yes
 If yes, please list:
 Type: _____ Date: _____ / _____ / _____
 Type: _____ Date: _____ / _____ / _____
 Type: _____ Date: _____ / _____ / _____
 Type: _____ Date: _____ / _____ / _____
 Type: _____ Date: _____ / _____ / _____

2. Have you had any previous studies? No Yes
 If yes, please list:

	<u>Body part</u>	<u>Date</u>	<u>Facility Location</u>
MRI	_____	_____/_____/_____	_____
CT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____

3. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, foreign body)? No Yes
 If yes, please describe: _____
4. Are you currently taking or have you recently taken any medication? No Yes
 If yes, please list: _____
5. Do you have anemia, hemolytic anemia, sickle cell anemia, sickle trait or any diseases that affect your blood? No Yes
 If yes, please describe: _____
6. Do you have a history of liver disease, renal disease, seizure, asthma or allergic respiratory disease? No Yes
 If yes, please describe: _____
7. Do you have any drug allergies? No Yes
 If yes, please list: _____
8. Have you ever had an allergic reaction or other reaction to a contrast medium or dye used for an MRI or CT examination? No Yes
 If yes, please describe: _____
9. Are you pregnant or experiencing a late menstrual period? No Yes
10. Are you breast-feeding? No Yes
11. Have you had Chemotherapy or Radiation Therapy? No Yes

IF FEMALE, AND HAVING AN MRI OF THE BREAST OR PELVIS, PLEASE COMPLETE QUESTIONS 11 -13.

12. Are you Pre menopausal or Post menopausal Date of last menstrual period: _____ / _____ / _____
13. Are you taking any type of fertility medication or having fertility treatments? No Yes
14. Are you taking oral contraceptives or receiving hormone treatment? No Yes

Continued on other side

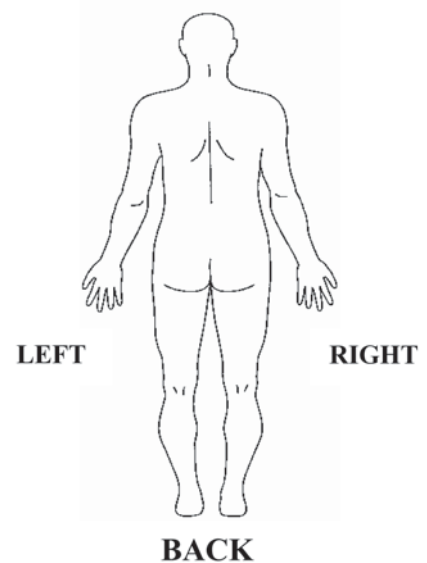
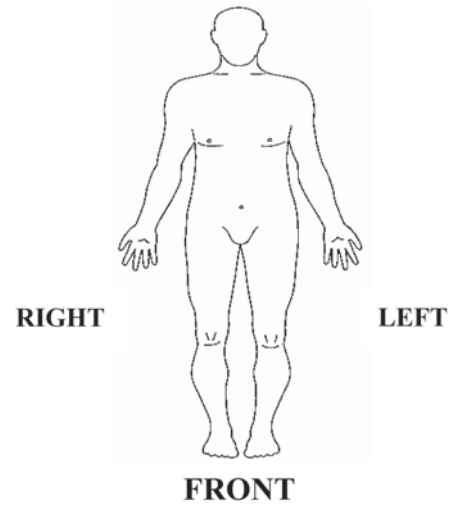


Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following?

- Yes No Cardiac pacemaker
- Yes No Implanted cardiac defibrillator
- Yes No Aneurysm clip(s)
- Yes No Carotid artery vascular clamp
- Yes No Neurostimulator or biostimulator
- Yes No Implanted insulin pump or infusion pump
- Yes No Implanted drug infusion device
- Yes No Bone growth/fusion stimulator
- Yes No Cochlear implant or other ear implant
- Yes No Penile implant
- Yes No Artificial heart valve
- Yes No Artificial limb or joint
- Yes No Eye implant or eyelid spring
- Yes No Intravascular stent, filter or coil
- Yes No IVC filter
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Swan-Ganz catheter
- Yes No Implant held in place by a magnet
- Yes No Medication skin patch (Nitro)
- Yes No IUD, diaphragm or pessary
- Yes No Tattooed makeup (eyeliner, lips, etc.)
- Yes No Body piercing(s)
- Yes No Metal fragments
- Yes No Internal electrodes or 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)/spinal fusion rods
- Yes No Tissue expander (e.g. breast)
- 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*)

Other, please explain: _____

On the figure below, please shade in the area where you are experiencing pain or discomfort.



Before your MRI, please remove all metallic objects including wigs, hairpins, barrettes, jewelry, watch, safety pins, paperclips, money clip, keys, coins, pens, credit cards, beepers, cellular phones.

Remove all clothing except your underpants, shoes and socks and put on the hospital gown given to you.

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

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Signature of: Parent Legal Guardian Designated Surrogate Proxy

Signature of Parent or Legal Guardian

Reviewed by

Relationship to Patient

