MRI HISTORY AND SCREENING FORM

Patient Name: _____ **Date of Birth:** _____

Sex: M F **Height:** _____ **Weight:** _____

Reason you are here today? Explain your medical problem in detail. (What is the problem? Where is the problem? Etc...)

_____

_____

Is your problem related to an injury? ☐ Yes ☐ No **If yes, Date of injury?** _____

How were you injured? ☐ Work ☐ Motor Vehicle Accident ☐ Other

Have you taken any sedation/alcohol today to relax you for this procedure? ☐Yes ☐ No **If yes, what?** _____

If yes, do you have someone to drive you home? ☐ Yes ☐ No

Do you have or have you ever had any of the following?

☐ Yes ☐ No **Cardiac Pacemaker:** _____

☐ Yes ☐ No **Heart Surgery/Heart Valve: If Yes, explain:** _____

☐ Yes ☐ No **Implanted Cardiac Defibrillator (ICD):** _____

☐ Yes ☐ No **Brain Aneurysm Clips/ Brain Surgery: If Yes, explain:** _____

☐ Yes ☐ No **Shunts/Stents/Filters/Intravascular Coil:** _____

☐ Yes ☐ No **Eye Surgery/Implants/Spring/Wires/Retinal Tack:** _____

☐ Yes ☐ No **Injury to the Eye Involving Metal or Metal Shavings:** _____

☐ Yes ☐ No **Orthopedic Pins/Screws/Rods/Joints/Prosthesis:** _____

☐ Yes ☐ No **Neurostimulator/Biostimulator:** _____

☐ Yes ☐ No **History of Cancer or Tumors: When:** _____ **Where:** _____

☐ Yes ☐ No **Radiation Therapy/Chemo Therapy:** _____

☐ Yes ☐ No **Previous Back Surgery (Lumbar/Thoracic/Cervical): When:** _____ **Levels:** _____

☐ Yes ☐ No **Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis:** _____

☐ Yes ☐ No **Vascular Access Port/Catheter:** _____

☐ Yes ☐ No **Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes:** _____

☐ Yes ☐ No **Electrical/Mechanical/Magnetic Implants? Type:** _____

☐ Yes ☐ No **Implanted Drug Infusion Pump/Insulin Pump:** _____

☐ Yes ☐ No **Are you Pregnant? When was your last Menstrual Period/Cycle?** _____

☐ Yes ☐ No **Tattoo's/Permanent Make-up/Body Piercing/Patches:** _____

☐ Yes ☐ No **Dentures/Partials/Dental Implants:** _____

☐ Yes ☐ No **Gunshot Wounds/Shrapnel/BB:** _____

☐ Yes ☐ No **Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig:** _____

List any Drug Allergies: _____

List Previous Surgeries: _____

List any Medications you're presently taking: _____

If you wear Habitrol and/or Transderm Scop patches they must be removed before you enter the MRI room. No exceptions.

MRI Contrast History: ☐Not applicable to this exam

Have you ever had MRI contrast? ☐ Yes ☐ No

Did you have any kind of reaction? ☐ Yes ☐ No **If yes, explain:** _____

Are you breast feeding at this time? ☐ Yes ☐ No

Do you have any history of Renal disease? ☐ Yes ☐ No

Do you have any history of Hypertension? ☐ Yes ☐ No

Do you have any history of Diabetes? ☐ Yes ☐ No

Have you ever had severe hepatic disease or liver transplant or pending liver transplant? ☐ Yes ☐ No

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

_____ _____ _____

Patient/Parent/Legal Guardian **MRI Technologist's Signature** **Date**

FOR TECHNOLOGIST USE ONLY

Type of Contrast: _____ **Contrast Temperature:** _____

Lot Number: _____ **Expiration Date:** _____

Time of Injection: _____ **Amount:** _____

LOWCOUNTRY ORTHOPAEDICS
CONSENT FOR DIAGNOSTIC EVALUATION
BY MAGNETIC RESONANCE IMAGING
(MRI)

To aid in diagnosing your medical condition, a scan using Magnetic Resonance Imaging has been ordered by your physician. This scan will provide detailed images by using magnetism, radio waves, and computerized digital imaging.

The MRI scan includes the following:

1. An explanation of the risk for injury caused by metal objects within or on the body

2. A completed patient screening questionnaire which documents:

   You do not have any metal objects such as pacemakers, surgical clips, implants, tattooed eyeliner, or any type of metal within your body.

   That to the best of your knowledge you are not pregnant.

   Whether you suffer from claustrophobia or panic attacks.

3. During the scan, you will lie on a table that slides into a large white cylinder. You be asked to lay still for approximately 45-60 minutes. You will be given head phones or ear plugs due to the loud repetitive noise from the MRI scanner.

The Food and Drug Administration (FDA) has approved Magnetic Resonance Imaging (MRI) as a safe medical device for patient diagnostic imaging. Extensive evaluation has shown no hazard from diagnostic MRI procedures. However, this is new technology and long term effects are unknown.

I acknowledge that this MRI procedure has been adequately explained and I have been given the opportunity to ask questions. I have read and understand this consent and authorize the performance of _____ MRI scan.

_____ _____

Signature of Patient or Guardian Witness

_____

Date