IMAGING

*For office use only COPAY:
Auth: _____
MRI Appointment: _____
Requesting Physician: _____
Next Appointment: _____
#PAT_____

Name: _____ DOB: _____ Sex: _____ Weight: _____

PLEASE BE DESCRIPTIVE AS POSSIBLE WITH THE INFORMATION REGARDING YOUR PAIN /AREA OF INTEREST

- Date of injury or onset of symptoms: _____
- Any injury to the affected area? No Yes How did injury occur? _____
- What problems or symptoms are you experiencing that resulted in your doctor ordering this test? _____

  _____

  _____
- Please list any previous testing (MRI, CT, or X-Ray) performed on the body part that is being scanned today: _____

  _____
- Please list any previous surgery to the body part being scanned today: _____
- Have you ever been diagnosed with cancer? Yes (please specify): _____ No
- Date of last menstrual cycle (females only): _____
- Do you require any of the following (circle Yes or No)?
  - Yes No Wheelchair (MR safe wheelchair is provided)
  - Yes No Supplemental Oxygen (Patient must bring longer tubing)
  - Yes No Language Interpreter (Cyracom (tablet) provided)

The following items can present significant health safety hazards in the MRI environment. If you have any of the following items, implants, devices, or conditions, you must notify the MRI technologist before entering the MRI scan room.

- **Please circle Yes or No for each item, implant, device, and condition listed below:**

Yes	No	Cardiac Pacemaker/Lead Wires	Yes	No	Brain Aneurysm Clips or Shunt
Yes	No	Defibrillator	Yes	No	Artificial Heart Valves
Yes	No	Neurostimulator-MODEL #_____	Yes	No	Other Stimulators
		***STOP If any above are Yes – MRI will call to schedule ***			
Yes	No	Artificial Limbs or Joint Replacements	Yes	No	Prosthesis (Orbital or Penile)
Yes	No	Metal Implants: Where? _____	Yes	No	Hearing Aids or Dentures
Yes	No	Welding, Metal Slivers, Shavings in eyes	Yes	No	Pregnant or Breast Feeding
Yes	No	Insulin/Drug Infusion Pump, Glucose Monitor	Yes	No	IUD/Pessary Ring
Yes	No	Stent/Wire in blood vessel: Where? _____	Yes	No	Transdermal Patch
Yes	No	Bullet/BB Fragments/Shrapnel	Yes	No	Body/Ear Piercings
Yes	No	Facial Injury from Metal	Yes	No	Claustrophobic/Pre Medicated?
Yes	No	Ear/Eye Implants	Yes	No	Other:

I have answered these questions to the best of my knowledge and understand the information presented to me. A report will be generated to your ordering physician within 24-48 hours of your findings. Your physician will advise you of your results.

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date: _____