IMAGING

Auth:____________________________
Requesting Physician: ______________
Next Appointment: ________________

Name: _____________________________________ DOB: _______________ Sex: ______ Weight: ________ MRN:___________

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

Date of injury or onset of pain / illness: ___________________

Any injury to the affected area: Yes No

What problems or symptoms are you experiencing that resulted in your doctor ordering this test? ___________________________

____

Please list any previous testing 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, Please Circle: Wheelchair Supplemental Oxygen Language Interpreter

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 Y for Yes or N for No for each item, implant, device, and condition listed below:

Y / N	**Cardiac Pacemaker / Lead Wires**	**Y / N**	**Hearing Aids or Dentures**
****Y / N**	**Neurostimulator ____________________**		
Y/ N	**Other Stimulator____________________**	**Y / N**	**Artificial Limbs or Joint Replacements**
Y / N	**Brain Aneurysm Clips**	**Y / N**	**Metal Implants or Body Piercings**
Y / N	**Insulin or Drug Infusion Pump**	**Y / N**	**Prosthesis (Orbital, Joint, or Penile)**
Y / N	**Stent or Wire in Blood Vessels / Shunts**	**Y / N**	**Artificial Heart Valves**
Y / N	**Bullet / BB Fragments / Shrapnel**	**Y / N**	**Pregnant or Breast Feeding (females only)**
Y / N	**Cochlear, Otologic, or Other Ear Implants**	**Y / N**	**IUD / Pessary Ring (females only)**
Y / N	**Facial Injury from Metal**	**Y / N**	**Transdermal Patch**
Y / N	**Welding, Metal Slivers / Shavings in Eyes**	**Y / N**	**Claustrophobic/Pre-Medicated?**

****If Yes to Neurostimulator: you must have model number noted or appt cannot be scheduled.**

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: ______________________

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