

Magnetic Resonance (MR) Procedure Screening for Patients

Name _____ Age _____ Height _____ Weight _____

Date of Birth _____ Gender: M / F Area to be examined: _____

Ordering Physician: _____ Primary Care Physician: _____

Do you have a scheduled follow up appointment to go over these results? Yes / No if so when: _____

Do you want the result to go to another provider? If Yes then, provide name and phone # _____

Please describe in your own words your pain or the reason you are here today, please be as descriptive as possible:

PLEASE INDICATE IF YOU HAVE ANY PERSONAL HISTORY OF:

- | | | |
|-----|----|--|
| YES | NO | Cardiac pacemaker, Implanted cardiac defibrillator |
| YES | NO | Aneurysm Clip(s) |
| YES | NO | Neurostimulator, Any type of biostimulator: Type: _____ |
| YES | NO | Any type of internal electrode(s), incl Pacing wires |
| YES | NO | Implanted insulin pump, Implanted drug infusion device |
| YES | NO | Any type of electronic, mechanical, or magnetic implant. Type: _____ |
| YES | NO | Cochlear, otologic or other ear implant |
| YES | NO | Hearing Aid |
| YES | NO | Any type of intravascular coil, filter, or stent, including cardiac, (e.g. Gianturcocoil, Gunther IVC filters, Palma-stent, etc.) |
| YES | NO | Claustrophobia? |
| YES | NO | History of Cancer |
| YES | NO | Asthma |
| YES | NO | Anemia |
| YES | NO | Kidney Disease |
| YES | NO | Seizure Disorder |
| YES | NO | Diabetes |
| YES | NO | Hypotension/Hypertension |
| YES | NO | Metal removed from your eyes, If so which eye: _____ |
| YES | NO | Worked with metal fragments, i.e. welding, grinding, etc. Did you wear safety glasses? _____ |
| YES | NO | Any type of prosthesis such as heart valve, penile, artificial limb or joint |
| YES | NO | Dentures |
| YES | NO | Diaphragm / IUD / pessary |
| YES | NO | Any type of foreign body, shrapnel, or bullet |
| YES | NO | Any type of surgical or orthopedic metal such as pines, rods, screws, nails, clips, plates, wires, staples, mesh, etc. Type: _____ |
| YES | NO | Body piercing(s) Location: _____ |
| YES | NO | Tattoo or permanent make up |
| YES | NO | Possibility of pregnancy. LMP: _____ |
| YES | NO | Are you currently breastfeeding? |

Questions continue on next page.

Welcome to our Imaging Center

Have you had a prior study related to this problem? (MRI, CT, Ultrasound, or X Ray) _____

When ? _____ Where? _____

List all previous surgeries: _____

Are you currently taking or have you recently taken any medications? _____

List any drug or latex allergies: _____

Have you ever had an allergic reaction to IV contrast used for MRI, CT, or X-ray? _____

If so please explain: _____

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 opportunity to ask questions regarding the information on this form.

I am consenting to treatment at Round Rock Imaging LTD

Patient or Parent/Guardian Signature: _____ Date: _____

MRI Tech Signature _____ Date _____

Technologist Portion

Contrast Type: _____	Volume: _____	
Lot #: _____	Exp. Date: _____	Location: _____
# of Attempts: _____	Was the power injector used? <input type="checkbox"/> Yes <input type="checkbox"/> No	Rate of injection: _____
Post contrast reaction <input type="checkbox"/> Yes <input type="checkbox"/> No	Physician covering the injection: _____	

Technologist Comments: _____

Technologist signature: _____ Date: _____