CHOICE *Diagnostic Imaging*

MRI HISTORY

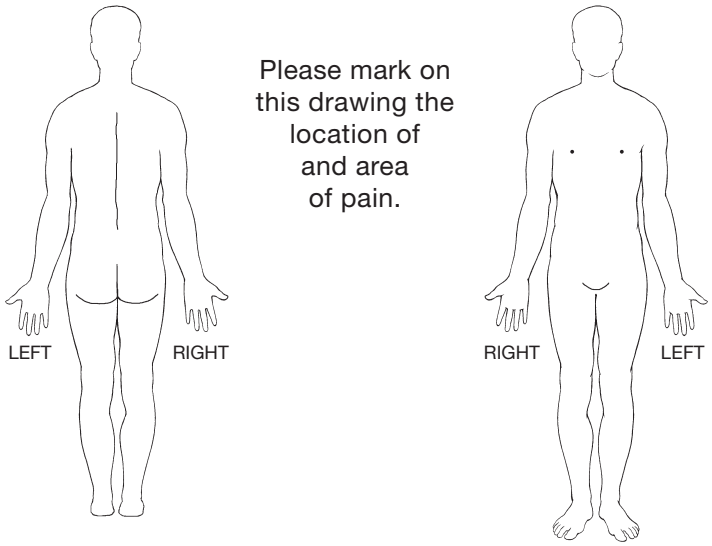
PLEASE PRINT. THANK YOU!

Name: _____ (LAST) _____ (FIRST) Exam Date: _____ Time: _____ Weight: _____

Referring Physician: _____ Age: _____ DOB: _____ Sex: _____

CC: _____

PATIENT HISTORY AND SCREENING



Please mark on this drawing the location of and area of pain.

CLINICAL INFORMATION

Area To Be Scanned: _____

_____

Diagnosis: _____

_____

HISTORY

Additional Information: _____

_____

_____

_____

_____

Protocol: _____

_____

PATIENT IS NOT PERMITTED TO WEAR EYE MAKE-UP OR HAIR SPRAY IF HAVING HEAD STUDY.

GADOLINIUM NOTIFICATION

On certain exams we may need to inject a special image enhancement agent (gadolinium) to improve the images that are created on your exam. This agent is safe. However, a small number of patients may experience headaches, nausea, or vomiting. Serious reactions occur in less than 1% of patients. Please let the technologist know if there is a history of sickle cell or hemolytic anemia. ***I have read and understand the above and give consent for this exam and the injection of gadolinium if necessary.***

PLEASE READ CAREFULLY

The following items can interfere with MR Imaging and some can actually be hazardous to patient safety.

PLEASE CIRCLE YES OR NO FOR ANY ITEMS:

Cardiac pacemaker/pacemaker lines	YES	NO
Automatic Internal Cardiac Defibrillator	YES	NO
Brain Aneurysm clips	YES	NO
Cochlear implant (ear surgery)	YES	NO
Cardiac Surgery in last 6 weeks	YES	NO
Tissue expander prior to breast implant	YES	NO
Insulin Pump	YES	NO
Neurostimulator (Tens-Unit)	YES	NO
Holter Monitor	YES	NO
Implants – Electrically, Magnetically or Mechanically Activated	YES	NO
Where? _____		
Shunts, stents, filter, or valves	YES	NO
Location: _____		
Type: _____		
Metal chips, foreign body or surgical device in eyes	YES	NO
Occupations with exposure to metal fragments	YES	NO
Shrapnel – Location: _____	YES	NO
Metallic foreign bodies		
Metal rods, metal plates, pins, screws, nails or clips	YES	NO
Aortic, brain, or carotid clips	YES	NO
Harrington rod	YES	NO
Prosthesis – Type: _____	YES	NO
IUD/Pessary	YES	NO
Tattoo, blepharopigmentation	YES	NO
Medicated dermal patch	YES	NO
Possibility of pregnancy LMP: _____	YES	NO
If yes, are you breast feeding?	YES	NO
Any history of renal disease or dialysis	YES	NO
Any history of asthma	YES	NO
Any history of allergic respiratory disease, drug allergies, or contrast agent allergies	YES	NO
Unable to lie flat	YES	NO
Claustrophobia – If yes, requires medication from physician prior to exam.	YES	NO
Needs assistance prior to exam	YES	NO
History of cancer	YES	NO
Where: _____		
What kind of treatment: _____		
Previous diagnostic exam	YES	NO
MRI / CT / Xray / Ultrasound / Mammo / P.E.T		
Body Part: _____		
Where Performed: _____		
Prior surgeries or operations	YES	NO
Type of surgery: _____		

_____

Patient Signature *(Guardian/Parent If A Minor)*

_____ _____

Witness Date