PATIENT HISTORY AND MRI SAFETY SCREENING

FOR OFFICE USE ONLY

PATIENT # _____

D.O.B. _____

PLEASE PRINT

NAME _____ AGE _____ SEX _____ WEIGHT _____

PLEASE PRINT

NAME OF THE PHYSICIAN WHO REFERRED YOU FOR MRI: _____

WHAT REASON OR SYMPTOMS LEAD YOU TO SEEK MEDICAL HELP? _____

_____

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

The following items can interfere with the Magnetic Resonance Imaging and some may be hazardous to your safety. Please indicate with check mark if you do or do not have any of the following:

* CARDIAC PACEMAKER _____ YES _____ NO
* ARTIFICIAL HEART VALVE _____ YES _____ NO
* BIO OR NEUROSTIMULATOR _____ YES _____ NO
* COCHLEAR IMPLANTS (EAR) _____ YES _____ NO
* CLAUSTROPHOBIA _____ YES _____ NO
* METALLIC IMPLANT _____ YES _____ NO
* HISTORY OF METAL WORKING _____ YES _____ NO
  IF YES, SPECIFY: _____
* ANY METAL IN YOUR BODY _____ YES _____ NO
  BY OPERATION OR ACCIDENT _____
  LIST: _____
* ANY METAL IN YOUR EYES _____ YES _____ NO
  BY OPERATION OR ACCIDENT _____
  LIST: _____

* SURGICAL CLIPS _____ YES _____ NO
* BRAIN ANEURYSM CLIPS _____ YES _____ NO
* SPINE OR BACK SURGERY _____ YES _____ NO
* ANY OTHER SURGERY _____ YES _____ NO
  LIST TYPES AND DATES: _____
  _____
* MEDICATION PATCHES, BANDAGES _____ YES _____ NO
* TATTOO _____ YES _____ NO
* ARE YOU PREGNANT NOW _____ YES _____ NO
* PERMANENT EYELINER _____ YES _____ NO
* ANY KNOWN ALLERGIES _____ YES _____ NO
  LIST: _____

HAVE YOU HAD A PREVIOUS MRI?

_____YES _____ NO, WHEN _____ WHERE _____

HAVE YOU HAD A PREVIOUS CT SCAN?

_____YES _____ NO, WHEN _____ WHERE _____

HAVE YOU HAD A MYELOGRAM?

_____YES _____ NO, WHEN _____ WHERE _____

WHAT WERE THE RESULTS OF THE ABOVE TEST? _____

_____

PLEASE SIGN BELOW, INDICATING THAT YOU HAVE UNDERSTOOD AND ANSWERED ALL THE ABOVE QUESTIONS.

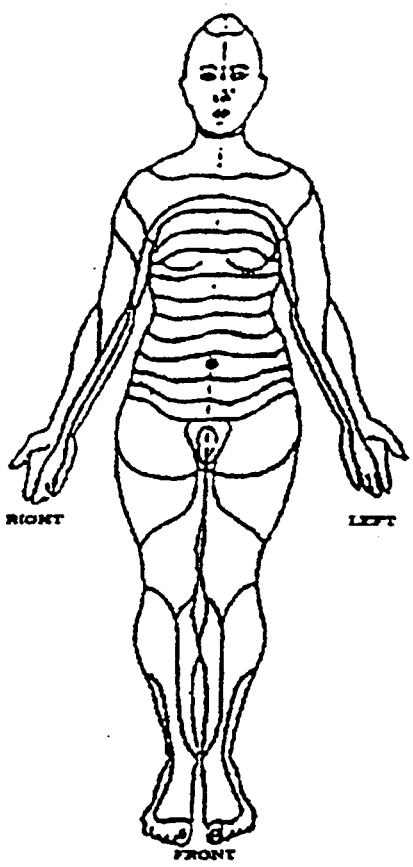
SIGNED _____ RELATION _____

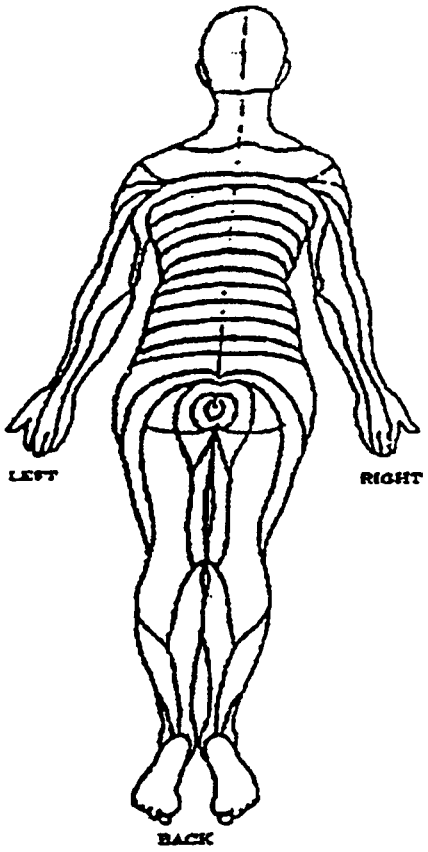
DATE _____ WITNESS _____

PLEASE TURN OVER AND COMPLETE TOP HALF OF THE BACK SIDE OF THIS FORM

With an X, a circle, or by shading, please indicate the areas where you are having pain, numbness, tingling, or other sensation.

Thank you for providing this important information. If you have any questions or need any assistance, please feel free to talk with any member of our staff.





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TECHNOLOGISTS NOTES: _____

_____

_____

_____

PRESUMED DIAGNOSIS: _____

ORBITAL SCREENING PERFORMED? _____ YES _____ NO; RAD. _____ ;RESULTS: _____

INTRAVENOUS MR CONTRAST SCREENING CHECKLIST: IF YES IS CHECKED, CONSULT WITH RADIOLOGIST TO DETERMINE IF CONTRAST IS INDICATED.

- PREGNANCY ____YES ____ NO; EXPLAIN _____
- DATE OF LAST MENSTRUAL PERIOD START: _____
- NURSING MOTHER ____YES ____ NO
- SICKLE CELL OR HEMOLYTIC ANEMIA ____YES ____ NO
- KNOWN SENSITIVITY TO MR CONTRAST ____YES ____ NO

IV CONTRAST ADMINISTERED? _____ YES _____ NO IF YES, DOSAGE: _____ TYPE: _____

REACTION: _____ F/U: _____

SEDATION ADMINISTERED? _____ YES _____ NO IF YES, DOSAGE: _____ TYPE: _____

TECHNOLOGIST INITIALS: _____