orthopedic ONE

MRI Screening Form

ID # _____ Images _____

Patient Name:_____ Date: _____

Date of Birth: _____ Weight: _____ Orthopedic ONE Physician: _____

List the exact area to be scanned including RT or LT (if applicable): _____

When did the injury ocur? _____

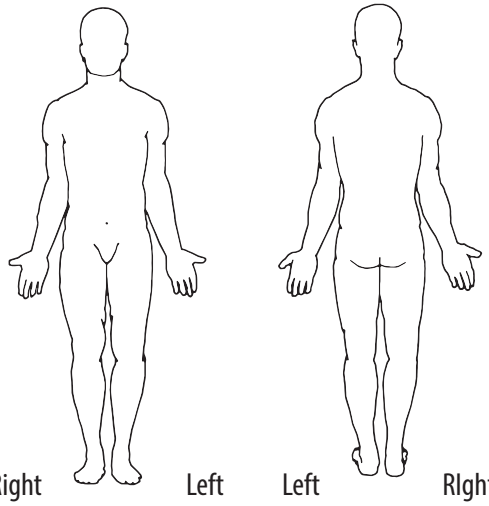
List all symptoms (if applicable): _____

_____

_____

_____

Please mark area of pain on the figures below



Right Left Left RIght

Have you had surgery or broken bones to the area <u>being examined</u>?

☐ YES ☐ NO. If yes, list date of surgery: _____

Have you had any other test to <u>this area</u>?

☐ X-ray – where: _____

☐ MRI – where: _____

☐ Other tests: _____

Have you ever received a steriod injection or taken steriods for you <u>current conditions</u>? ☐ YES ☐ NO. If yes, please explain: _____

_____

Have you ever had any surgical procedure or operations of any kind? ☐ YES ☐ NO. If yes, please list <u>all</u> prior surgeries and approximate date: _____

_____

Have you ever had an <u>EYE INJURY</u> involving a metallic object (e.g. metallic slivers, shavings, etc.): ☐ YES ☐ NO. If yes, please describe: _____

_____

Have yhou ever been injured by any metallic foreign body (e.g. bullet, BB, shrapnel, etc.): ☐ YES ☐ NO. If yes, please describe: _____

_____

Have you had a Colonoscopy/Endoscopy in the last 8 weeks? ☐ YES ☐ NO.

Have you ever been diagnosed with cancer? ☐ YES ☐ NO. If yes, please explain: _____

_____

Did you receive: Radiation Treatment ☐ YES ☐ NO. Chemotherapy ☐ YES ☐ NO.

PLEASE TURN PAGE OVER TO CONTINUE

To be completed by MRI Staff

Form Reviewed by: _____ Procedure: _____

Diagnosis: _____ Technologist: _____

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment if they have certain metallic, electronic, magnetic or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment. If you answer "yes" to any of the questions below or have any concerns please consult the MRI technologist BEFORE you enter the MR system room. In addition, the Radiologist requires the clinical information for their interpretation.

Do you have any of the following? (Please check correct answer)

☐ YES ☐ NO Cardiac Pacemaker
☐ YES ☐ NO Implanted Cardiac Defibrillator
☐ YES ☐ NO Aneurysm Clip(s)
☐ YES ☐ NO Carotid Artery Vascular Clamp
☐ YES ☐ NO Internal Pacing Wires
☐ YES ☐ NO Insulin or Drug Infusion Pump
☐ YES ☐ NO Bone Growth Stimulator
☐ YES ☐ NO Cochlear, Otologic or Ear Implant
☐ YES ☐ NO Prosthesis (eye, penile, etc.)
☐ YES ☐ NO Heart Valve Prosthesis
☐ YES ☐ NO Intravascular stents, filters or coils
☐ YES ☐ NO Shunt (spinal or intraventricular)
☐ YES ☐ NO Vascular access port or catheter
☐ YES ☐ NO Glucose Monitoring Device
☐ YES ☐ NO Neurostimulator
☐ YES ☐ NO Aortic clip
☐ YES ☐ NO Metal rods in bones
☐ YES ☐ NO Bone/Joint pin,screw,nail,wire,plate

☐ YES ☐ NO Wire sutures or surgical clips
☐ YES ☐ NO Metal or wire mesh implants
☐ YES ☐ NO Swan-Ganz catheter
☐ YES ☐ NO Joint replacement
☐ YES ☐ NO Artificial limb or joint
☐ YES ☐ NO Any metal fragments
☐ YES ☐ NO Any implant held in place by a magnet
☐ YES ☐ NO Transdermal delivery system (Nitro)
☐ YES ☐ NO IUD or diaphragm
☐ YES ☐ NO Tattoos
☐ YES ☐ NO Body Piercing
☐ YES ☐ NO Cosmetics held in place by a magnet
☐ YES ☐ NO Hearing aid
☐ YES ☐ NO Dentures
☐ YES ☐ NO Breathing disorder
☐ YES ☐ NO Harrington rods (spine)
☐ YES ☐ NO Electrodes (on body)
☐ YES ☐ NO Claustrophobia

Other - please note:_____

Females Only

Are you currently pregnant or suspect that you are pregnant? ☐ YES ☐ NO

IMPORTANT INSTRUCTIONS

Before entering the MR environment or the MR system room, you must remove all metallic objects including but not limited to: hearing aids, eyeglasses, keys, beeper, cell phone, wallet, credit cards, bank cards, magnetic strip cards, money clips, coins, pens, pocket knife, nail clippers, hair pins, safety pins, barrettes, jewelry, watch, paper clips, tools, clothing with metal fasteners and metallic threads.

Hearing protection is required during your MRI exam.

I attest that the above information is correct to the best of my knowledge, I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. I therefore give my consent for this MRI scan.

_____ Date: _____

Signature of patient

Form completed by: ☐ Patient ☐ Other: _____

Name and Relationship to patient