Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Height: \_\_\_\_\_\_ Weight: \_\_\_\_\_

Last Name First Name Middle Initial

**Warning:** **The MRI magnet is ALWAYS ON.** Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. Consult the MRI technologist and ask any questions before entering the MRI room for your exam.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please check yes or no on the following questions. | | | Please mark where your pain in located on the | |
| □ Yes | □ No | Cardiac Pacemaker, internal electrodes or wires | diagram below: | |
| □ Yes | □ No | Brain aneurysm clip(s) |  |  |
| □ Yes | □ No | Implanted cardioverter defibrillator |
| □ Yes | □ No | Electronic implant or device |
| □ Yes | □ No | Neurostimulation device |
| \*\***If yes to any of the questions above please stop, you cannot have an MRI.**\*\* | | |
| □ Yes | □ No | Are you on dialysis |
| □ Yes | □ No | Any history of metal work, welding or grinding |
| □ Yes | □ No | Bone growth stimulator |
| □ Yes | □ No | Insulin or other infusion pump |
| □ Yes | □ No | Any type of prosthesis *(penile, limb, etc.)* |
| □ Yes | □ No | Shunt |
| □ Yes | □ No | Metallic stent, filter or coil |
| □ Yes | □ No | Swan-Ganz catheter |
| □ Yes | □ No | Tissue Expander *(e.g. breast)* |
| □ Yes | □ No | Medication patches |
| □ Yes | □ No | Any metallic fragment or shrapnel within your body |
| □ Yes | □ No | Cochlear implant, cataract surg or eyelid spring/wire | Please list any surgeries you have had on the  area being scanned today: | |
| □ Yes | □ No | Body piercings, tattoos, permanent makeup |
| □ Yes | □ No | Removable dental work *(Remove before MRI)* |  |  |
| □ Yes | □ No | Hearing Aids *(Remove before MRI)* |  | |
| □ Yes | □ No | Claustrophobic |  | |
| □ Yes | □ No | Breathing problem or motion disorder |  | |
| □ Yes | □ No | Reaction to MRI Gadolinium contrast |  | |
| □ Yes | □ No | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | |
| **Women Only** | | Are you pregnant or nursing: □ Yes □ No |  | |
|  | | IUD or diaphragm □ Yes □ No |  | |

**Note**: Hearing protection is required during the MRI exam to prevent possible problems or hazards related to acoustic noise. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are language interpretive services needed for this encounter? □ Yes □ No If yes, ref #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that the information above is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Completing Form Date Time

Form completed by: □ Patient □ Relative □ Other – relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Form information reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_