MRI SCREENING FORM FOR PATIENTS

MRI appointment: ________________

Please check in 10 minutes early to prepare for your _____:______ exam.

Expected duration: _______________

MRI LOCATION & CHECK IN:

Please check in with the ORTHOPEDIC ASSOCIATES front desk receptionist and hand in this completed form. Failure to complete this form may result in your MRI being rescheduled.

MRI CANCELLATION POLICY:

IF YOU FAIL TO CANCEL YOUR APPOINTMENT WITHOUT 24 HOUR NOTICE YOU MAY BE CHARGED A $75.00 FEE. If you need to change this appointment, please contact our MRI Coordinator at (530) 897-4500 EXT 157. Messages may be left at any time.

DATE: ______/______/_______ NAME: ____ MALE [ ] FEMALE[ ]

(Last Name, First Name, Middle Initial)

DATE OF BIRTH: ______/______/_______ AGE: _________ Height: ___________ Weight: ___________

Physician (*please circle one*): Dr. Azevedo, Dr. Brazil, Dr. Castro, Dr. Doherty, Dr. Granlund, Dr. Harwood, Dr. Komas, Dr. Konkin, Dr. Landaker, Dr. Morris, Dr. Watson, Dr. Wilhite

1.) Body part being imaged today: ____

2.) Have you had an injury or is this an ongoing/chronic problem? ______________________________

3.) Have you had surgery in the area being scanned? ☐ Yes ☐ No *If yes, please fill in the following:*

Date: _____/_______ Type of Surgery: ________________________________ Surgeon and/or Facility: ______________________

4.) Have you had any imaging performed on this body part outside our office (e.g., MRI, CT, Ultrasound, X-Ray, etc.)? ☐ Yes ☐ No

If yes, please list: TYPE OF STUDY _____________________ *DATE* _____/_____/_____ *FACILITY* ____________________

5.) Have you had any type of surgery in the last six weeks? ☐ Yes ☐ No

6.) Have you ever had any other medical conditions? ____

7.) Do any of the following apply to you?

Cardiac pacemaker	☐ Yes ☐ No	*Mechanical heart valve, aortic clip, cardiac stent*	☐ Yes ☐ No
Pacemaker wires	☐ Yes ☐ No	*Medication patch -if yes, where:*	☐ Yes ☐ No
Cerebral aneurysm clip	☐ Yes ☐ No	*Metallic object in eye (shavings, fragments,flakes)*	☐ Yes ☐ No
Implanted neurostimulator	☐ Yes ☐ No	*Tattoo*	☐ Yes ☐ No
Cochlear (Ear) implant	☐ Yes ☐ No	*Body piercings*	☐ Yes ☐ No
Bullets or shrapnel	☐ Yes ☐ No	*Hearing aids*	☐ Yes ☐ No
Joint replacement	☐ Yes ☐ No	*Removable dentures/partials or a permanent bridge*	☐ Yes ☐ No
Insulin/infusion pump	☐ Yes ☐ No		
Intra-uterine device	☐ Yes ☐ No	*Any additional implant or metal in your body*	☐ Yes ☐ No
Breast expanders (not implants)	☐ Yes ☐ No	*Motion disorder*	☐ Yes ☐ No
		Claustrophobia	☐ Yes ☐ No
Orthopedic hardware	☐ Yes ☐ No		

8.) FEMALE patients: Is there any possibility you are pregnant? ☐ Yes ☐ No

⚠ WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist and/or the MRI Coordinator BEFORE entering the MR system room. The MR system magnet is ALWAYS on. **Before entering the MR environment, you must remove ALL metallic objects.*

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

Signature: ____ Date _____/_____/_____ Relation: ___________________________

Notification of Ownership

In order to better evaluate and treat your condition, your physician feels that a Magnetic Resonance Image (MRI) is required. Orthopedic Associates is able to perform the MRI here in our office. We must advise you that Orthopedic Associates has ownership in this diagnostic tool. You have the option to choose an outside facility for your MRI and we are happy to refer you to the facility of your choice.

Please sign below if you elect to have your MRI here at Orthopedic Associates.

Signature: ____ Date _____/_____/_____

(In Office Use Only)

Form Information Reviewed By: ______________________________ *MRI Technologist [ ]* Date _____/_____/_____