BONE & JOINT SPECIALISTS
ORTHOPEDIC CENTER

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PLEASE FAX BOTH SIDES

MAGNETIC RESONANCE IMAGING (MRI) PATIENT SCREENING FORM

Every patient scheduled for MRI MUST complete the following questionnaire prior to having the MRI. The technologist will be available to answer any of your questions or concerns.

Patient Name: **Date:** **Sex: M F**

Birth Date: **Age:** **Height:** **Weight:** **Dr.**

DO YOU HAVE:	**Yes**	**No**	**Unsure**	**If yes, please explain**
A history of cancer/tumors				
Cardiac (Heart) Pacemaker or Wires (at any time in your life)				
Artificial heart valves				
Brain aneurysm clips				
Metal in your eyes (at any time in your life)				
Implanted electrodes, pumps or catheters				
Neurostimulators				
Shrapnel, bullets, or other metal fragments				
Any tattoos (including permanent makeup)				
Ear implants (cochlear, stapes) / Hearing aid				
Orthopedic (bone) screws, pins, plates, rods (if yes, state location)				
Breast tissue expander or other implants				
Prosthesis (eye, penile, leg, arm, hip, etc.)				
Any stents, coils or filter in blood vessels				
Dentures, retainer, braces, magnetic implants				
Transdermal medication patches (examples: nitroglycerin for heart or nicotine to stop smoking)				
Body piercing other than earrings				
HAVE YOU EVER HAD SURGERY OR OPERATION ON:				
Brain, eye, ear, nose				
Heart				
Neck, chest, back (spine)				
Abdomen, pelvis, hips				
Leg, thigh, knee, ankle, toe				
Shoulder, arm, elbow, wrist, hand, finger				
ARE YOU:				
Pregnant				
Claustrophobic				

Please remove all your jewelry, watch, credit cards, coins and other metallic items (earrings, piercings, etc.) from your person. A MRI staff member will instruct you about securing your items prior to entry into the exam room. I understand the entire contents of this form. I affirm that the information is true to the best of my knowledge. I hereby consent to the MRI study.

PLEASE FAX BOTH SIDES

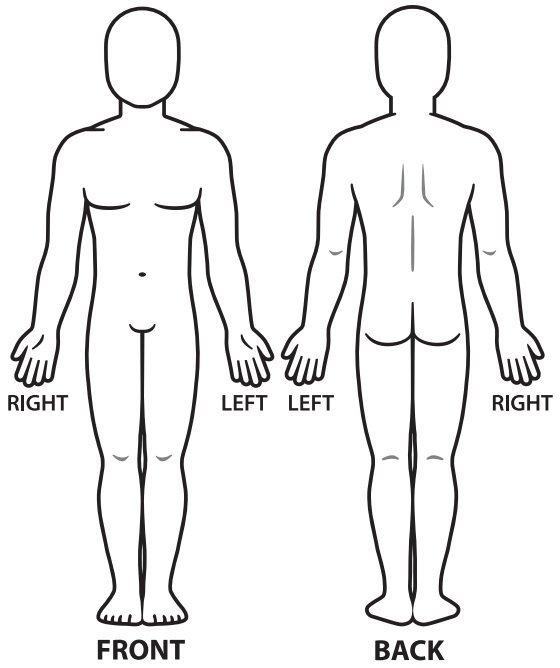
Signature of patient completing this form _____ Date _____

Relationship to patient if form not completed by patient _____ Review Date _____

Signature of Technologist _____ Date _____

Area to write detailed history of any problems:

Please mark any areas of pain on body:



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room.