MRI of Springfield
Magnetic Resonance Imaging Screening Form

Name: _____ Today's Date: _____

Gender: ____M____F Date of Birth: _____ Height: _____ Weight: _____

Ordering Doctor: _____ Type of Study: _____

Is this exam related to an accident? ____Y ____N Date of Accident: _____

Type of accident: Work Comp_____ Motor Vehicle_____ Other_____

Due to the magnetic field an assessment to determine your safety during the procedure is necessary. Please answer the following questions.

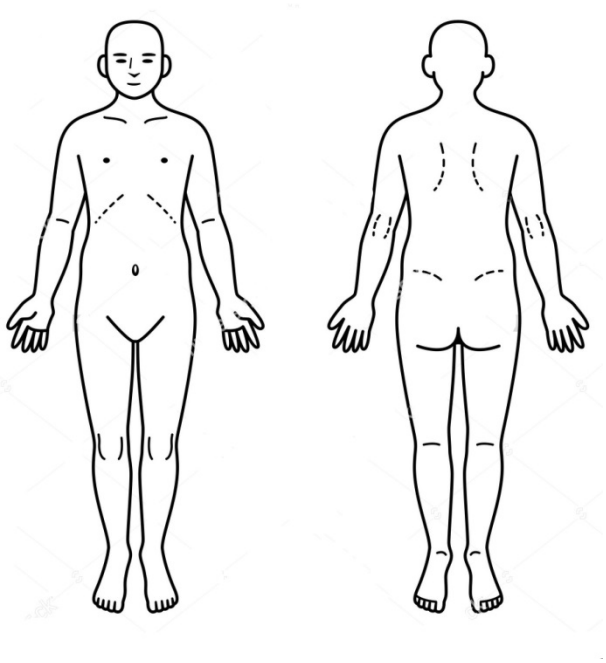
Do you currently have, or have you ever had:

1. Cardiac pacemaker/pacer wires	___Yes___No	12. IUD or diaphragm	___Yes___No
2. Implanted defibrillator	___Yes___No	13. Intestine capsule	___Yes___No
3. Internal electrodes or wires	___Yes___No	14. Shunt (spine/brain)	___Yes___No
4. Cardiac valve	___Yes___No	15. Artificial limb/joint	___Yes___No
5. Stents: Cardiac, Renal or Vascular	___Yes___No	16. Vena Cava filter	___Yes___No
6. Date of placement		17. Any prosthetics	___Yes___No
7. Brain surgery	___Yes___No	18. Metal fragments/shavings	___Yes___No
8. Date of surgery		19. Tattooed makeup	___Yes___No
9. Aneurysm clips	___Yes___No	20. Body piercings	___Yes___No
10. Implantable pumps	___Yes___No	21. Any other implanted devices or objects	___Yes___No
11. Stimulator (Bone or Neuro)	___Yes___No	Please List	

Please answer all of the following questions regarding your medical history

22. Have you ever done welding or machinist work	___Yes___No
23. Any history of diabetes	___Yes___No
24. Do you have history of hypertension	___Yes___No
25. Any history of renal disease, renal failure or renal dialysis	___Yes___No
26. Are you pregnant or breast feeding	___Yes___No
27. If no, please indicate birth control, hysterectomy, or menopause	
28. Do you have asthma or chronic lung disease	___Yes___No
29. Do you have a history of congestive heart failure	___Yes___No
30. Do you have dentures or hearing aides	___Yes___No
31. Do you wear a medication patch	___Yes___No
32. Are you claustrophobic	___Yes___No
33. Have you ever been diagnosed with cancer	___Yes___No
34. Location of cancer and date of diagnosis	
35. Chemotherapy Date of last treatment:	___Yes___No
36. Radiation therapy Date of last treatment:	___Yes___No
37. Have you had previous surgery or pain injection on **AREA OF EXAM**	___Yes___No
38. Date of surgery or injection	
39. Have you ever had a reaction to a contrast injection in the past (MRI or CT)	___Yes___No
40. Please list any allergies below (medications/latex/food)	

Please mark your area of pain or symptoms on the diagram related to **TODAY'S AREA OF EXAM.**



Please describe in detail symptoms' related to exam today.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you had any previous studies **ON AREA OF TODAY'S EXAM**? Please indicate below.

	Body Part	Date	Facility Location
MRI			
CT/CAT Scan			
Nuclear Medicine			
Ultrasound			
X-Ray			

Before your MRI you may be asked to change into appropriate clinical clothing for the procedure. At that time you will be asked to remove all metallic objects from your person. You will be required to wear hearing protection if having a closed MRI procedure. Hearing protection is available upon request for an open MRI.

To my knowledge the above statements are true and correct. I hereby consent to the MRI procedure and treatment as ordered by my healthcare provider. I further understand that I may refuse any or all of my procedure. I understand that if I refuse any or all of my procedure that I am doing so of my own free will and my healthcare provider will be contacted regarding my refusal.

Patients Name (please print) Patients Signature Date

Guardian's Name (please print) Guardian's Signature Relationship Date

Level II Technologist Signature* Date

*This signature indicates that the form has been reviewed and the patient has been cleared for entry into Zone IV