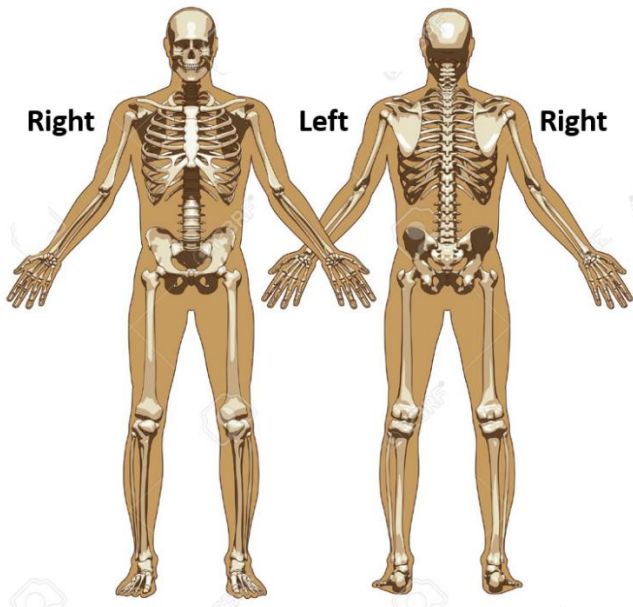


Name (Please Print): _____

*The MRI room contains a very strong magnet. Before you are allowed to enter the room we must know if you have any metal in your body. Some metal objects can interfere with your scan or even be dangerous, so please answer the following questions carefully.

Do you have any of the following?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cardiac pacemaker, pacemaker leads or defibrillator
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Brain aneurysm clip
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cochlear ear implant
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metal in eyes or previous injury to eyes involving metal
<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of kidney disease/injury or dialysis
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cerebral shunt
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye or ear implants
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metal shrapnel, bullets, BB's, or pellets
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted infusion pump or any mechanical or electrical implants
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Coil, filter or wire in blood vessel
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthopedic hardware (plates, screws, pins, rods, artificial limb or joint)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Implanted catheter or tube (Port-a-cath, Swan-Ganz)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgical clips, staples, wires, mesh or sutures
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nitropatch or other skin patches
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Piercing, tattoo or permanent makeup
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dentures or hearing aid
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnant, possibly pregnant or breast-feeding.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had any previous surgeries?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please state what type and when:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you (past/present) been diagnosed as having cancer?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please state what type and where:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had chemotherapy or radiation therapy?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Do you have hypertension (high blood pressure)?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you ever had an allergic reaction to MRI, CT or X-ray Contrast Agent



Regarding the diagram on the left:
 Place an "X" over the area of pain
 Place an "O" over the area of numbness/weakness



Patient Name (Please print) _____

Are your symptoms due to an accident or injury?

How did injury happen? _____ sports _____ lifting _____ a fall _____ auto accident _____
_____ work related _____ other _____

Which of the following best describes the injury? _____ twisting injury _____ hyperextension
_____ a direct blow to the front _____ a direct blow to the back _____ a direct blow to the side

Do any of the following describe your symptoms? _____ pain _____ locks up _____ swelling
_____ gives out _____ limitation of motion

How long have you had these symptoms? _____

Have you ever had surgery on this joint before? _____ Yes _____ No

If yes, when? _____

Have you ever had a fracture of this joint? _____ Yes _____ No

If yes, when? _____

Approximate date of accident or injury _____

Present Medications _____

List any prior imaging of the area to be scanned including approximate dates. (X-rays, CT, MRI, Ultrasound, Nuclear Medicine)?

As part of your exam, the MRI Radiologist may find it advisable to give you an intravenous injection of a contrast agent (dye). This injection may help the physician more accurately diagnose your condition. Although MRI contrast agents have been used safely in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients; whereas serious or life threatening reactions have been reported in about one in 400,000 patients.

All questions about the MRI exam are welcomed and no questions are considered unimportant. The MRI exam will be supervised and interpreted by a Board Certified Radiologist associated with Radiology Consultants of Mid-America,PC.

The MRI exam procedure has been explained to me fully. I acknowledge that medicine is not an exact science and I understand that the examination involves some element of risk despite precautions, and that there is a possibility of complications, either directly or indirectly, which may result. Possible common risks as well as the benefits associated with the MRI exam have been explained to me.

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM, AND HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION ON THIS FORM, AND REGARDING THE MRI PROCEDURE THAT I AM ABOUT TO UNDERGO.

X Signature (Patient or Guardian) _____ Date: ____/____/____

MRI Technologist _____ Date ____/____/____

