

BRAIN SCAN HISTORY FORM

SCAN # _____ TECH _____

PATIENT NAME _____ AGE _____ BIRTHDATE _____

REFERRING PHYSICIAN _____ HEIGHT _____ WEIGHT _____ SEX M F

1. What is the MAIN REASON for having this scan? _____

How long have you had these symptoms? _____

2. Have you ever had an MRI or a CT scan of your brain before? YES NO

If so, when and where? _____

3. Have you had a previous reaction to MRI/CT/XRAY Contrast? YES NO

If so, explain _____

4. Do you have HEADACHES? YES NO

Describe location and frequency _____

5. Have you ever had a HEAD INJURY? YES NO

AUTO INDUSTRIAL OTHER (explain) _____

Approximate Date _____

6. Have you ever had any BRAIN SURGERY? YES NO

If so, what type of surgery? _____

Approximate date _____

7. Have you ever had SEIZURES BLACKOUTS DIZZYSPELLS HEARING LOSS

8. Are you Diabetic? YES NO

9. Have you had BLOOD WORK in past 30 days? YES NO

Where? _____

10. Do you have WEAKNESS in your arms or legs? Arms Left Right

Legs Left Right

11. Have you ever been diagnosed with cancer? YES NO

If so what type and when _____

What treatment did you receive SURGERY RADIATION CHEMOTHERAPY NONE

IF YOU ARE PREGNANT PLEASE INFORM THE TECHNOLOGIST BEFORE BEING SCANNED

I am aware that there may be risks involved to my unborn child if exposed to either MR and/or CT examination. I accept full responsibility if any future complications should arise.

To the best of my knowledge I am not pregnant. _____

SIGNATURE

MRI SCREENING FORM

**THE FOLLOWING ITEMS MAY INTERFERE WITH MRI IMAGING,
AND SOME COULD BE HAZARDOUS TO YOUR SAFETY.**

Please place a check mark in either the YES or NO box for each question below.
If a particular question does not apply to you, then you should answer NO.

- | | |
|--|--|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> CARDIAC PACEMAKER (If YES, patient can not be scanned)</p> <p><input type="checkbox"/> <input type="checkbox"/> IMPLANTED AUTOMATIC DEFIBRILLATOR (If YES, patient can not be scanned)</p> <p><input type="checkbox"/> <input type="checkbox"/> BRAIN SURGERY CLIPS (aneurysm) (If YES, patient can not be scanned)</p> <p><input type="checkbox"/> <input type="checkbox"/> HAVE YOU EVER HAD A METAL INJURY TO YOUR EYES THAT REQUIRED A VISIT TO A DOCTOR?</p> <p><input type="checkbox"/> <input type="checkbox"/> ARE YOU PREGNANT OR NURSING?</p> <p><input type="checkbox"/> <input type="checkbox"/> ARE YOU ON DIALYSIS?</p> <p><input type="checkbox"/> <input type="checkbox"/> AORTIC OR CAROTID ARTERY CLIPS</p> <p><input type="checkbox"/> <input type="checkbox"/> HEART VALVE OR STENT</p> <p><input type="checkbox"/> <input type="checkbox"/> VASCULAR (umbrella) FILTER FOR CLOTS</p> <p><input type="checkbox"/> <input type="checkbox"/> INSULIN PUMP</p> <p><input type="checkbox"/> <input type="checkbox"/> COCHLEAR OR STAPES (inner ear) IMPLANTS</p> <p><input type="checkbox"/> <input type="checkbox"/> SHUNT (intraventricular or spinal)</p> <p><input type="checkbox"/> <input type="checkbox"/> TRANSDERMAL PATCH (nicotine, medication or hormones)</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> HEARING AID</p> <p><input type="checkbox"/> <input type="checkbox"/> JOINT REPLACEMENT</p> <p><input type="checkbox"/> <input type="checkbox"/> FRACTURED BONES TREATED WITH METAL (rods, plates, screws, nails or clips)</p> <p><input type="checkbox"/> <input type="checkbox"/> PROSTHESIS (limbs, joints or eyes)</p> <p><input type="checkbox"/> <input type="checkbox"/> WIRE SUTURES</p> <p><input type="checkbox"/> <input type="checkbox"/> SHRAPNEL (metal fragments)/ GUNSHOT INJURY</p> <p><input type="checkbox"/> <input type="checkbox"/> REMOVABLE DENTURES OR RETAINERS</p> <p><input type="checkbox"/> <input type="checkbox"/> OTHER METAL IMPLANTS</p> <p><input type="checkbox"/> <input type="checkbox"/> NEUROSTIMULATORS (tens units, bone growth stimulators, etc.)</p> <p><input type="checkbox"/> <input type="checkbox"/> IUD OR PENILE IMPLANT</p> <p><input type="checkbox"/> <input type="checkbox"/> BODY PIERCING- if YES, please indicate the location _____</p> <p><input type="checkbox"/> <input type="checkbox"/> RECENT TATTOOS (within 2 weeks of application)</p> <p><input type="checkbox"/> <input type="checkbox"/> TATOOED EYELINER</p> |
|--|--|

DATE _____ SIGNATURE _____

CONSENT FOR INTRAVENOUS CONTRAST FOR MRI

Your physician has referred you to our facility for magnetic resonance examination. In certain cases, intravenous contrast is used to enhance the images and provide better information. This medication is injected into a vein and highlights the structures of interest. This medication has been approved by the Food and Drug Administration as being safe and effective.

As with all medications, certain side effects and complications are possible. The injected contrast solution rarely causes headache, nausea or vomiting. Some laboratory blood tests in patients with anemia or other blood diseases may be temporarily altered by this medication.

I have read and understand the above explanation, and I give my consent to have Western Neurological Associates perform this test using intravenous contrast. I understand that in spite of every skill and prudent effort made to avoid complications during the procedure, there is no guarantee that a complication will not occur.

Signature of Patient _____

Signature of Parent/Guardian _____