

EXTREMITY HISTORY FORM

SCAN # _____ TECH _____

PATIENT'S NAME _____ AGE _____ BIRTHDATE _____

REFERRING PHYSICIAN _____ SEX M F HEIGHT _____ WEIGHT _____

1. What extremity is being scanned? _____ Right Left

2. What symptoms are you having? _____

3. How long have you had these symptoms? _____

4. Are these symptoms the result of an injury? YES NO Date _____

Auto Industrial Other _____

5. Have you had surgery on this area? YES NO

what type and when? _____

6. Have you had a MRI, CT, or XRAY of this area before? YES NO

where and when? _____

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

If so, what type and when? _____

What treatment did you receive? Surgery Radiation Chemotherapy None

8. Have you had a previous reaction to MRI, CT or XRAY contrast? YES NO

If so, explain _____

9. Are you Diabetic? YES NO

10. Have you had recent blood work in the last 30 days? YES NO where? _____

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

For Technologist Use ONLY: Indicate Specific Point of Interest

Anterior Posterior Medial Lateral Other _____

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.

YES NO

- CARDIAC PACEMAKER**
(If YES, patient can not be scanned)
- IMPLANTED AUTOMATIC DEFIBRILLATOR**
(If YES, patient can not be scanned)
- BRAIN SURGERY CLIPS (aneurysm)**
(If YES, patient can not be scanned)
- HAVE YOU EVER HAD A METAL INJURY TO YOUR EYES THAT REQUIRED A VISIT TO A DOCTOR?**
- ARE YOU PREGNANT?**
- HAVE YOU HAD A KIDNEY TRANSPLANT?**
- ARE YOU ON DIALYSIS?**
- AORTIC OR CAROTID ARTERY CLIPS**
- HEART VALVE OR STENT**
- VASCULAR (umbrella) FILTER FOR CLOTS**
- INSULIN PUMP**
- COCHLEAR OR STAPES (inner ear) IMPLANTS**
- SHUNT (intraventricular or spinal)**
- TRANSDERMAL PATCH**
(nicotine, medication or hormones)

YES NO

- HEARING AID**
- JOINT REPLACEMENT**
- FRACTURED BONES TREATED WITH METAL**
(rods, plates, screws, nails or clips)
- PROSTHESIS (limbs, joints or eyes)**
- WIRE SUTURES**
- SHRAPNEL (metal fragments)/ GUNSHOT INJURY**
- REMOVABLE DENTURES OR RETAINERS**
- OTHER METAL IMPLANTS**
- NEUROSTIMULATORS**
(tens units, bone growth stimulators, etc.)
- IUD OR PENILE IMPLANT**
- BODY PIERCING- if YES, please indicate the location** _____
- RECENT TATTOOS**
(within 2 weeks of application)
- TATOOED EYELINER**

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 examination, 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 complication during the procedure, there is no guarantee that a complication will not occur.

Signature of Patient _____

Signature of Parent/Guardian _____