

Patient Information Form – MRI

Patient Chart #: _____

Date: _____

[] Male [] Female

Patient Name: _____ Date of Birth: ____/____/____ SS#: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone #'s: (Home) _____ (Work) _____ (Cell) _____

Email Address: _____

Name of Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: _____ Phone #: _____/Fax#: _____

Additional Physician: _____ Phone #: _____/Fax#: _____

Primary Insurance Information

Insurance Company Name: _____

Insurance Group #: _____ Insurance ID#: _____

Are you the primary insurance carrier? YES NO

If **NO**, please fill out the following information:

Name of Primary Insurance carrier: _____ Relationship to Patient: _____

Date of Birth: ____/____/____ Primary Insurers SS#: _____ Phone #: _____

Secondary Insurance Information

Insurance Company Name: _____

Insurance Group #: _____ Insurance ID#: _____

Are you the secondary insurance carrier? YES NO

If **NO**, please fill out the following information:

Name of Secondary Insurance carrier: _____ Relationship to Patient: _____

Secondary Insurers Date of Birth: ____/____/____ Secondary Insurers SS#: _____ Phone #: _____

In the event of an emergency, please contact:

Name: _____ Relationship: _____ Phone #: _____

Why is your referring physician requesting that you have this exam? _____

Is there any possibility of pregnancy? YES NO

Do you have a pacemaker? YES NO

Do you have aneurysm clips? YES NO *(If, YES – STOP! This patient cannot have an MRI)*

Have you had any previous surgery to the location in which we will be scanning? YES NO

If YES, please list the type of surgery and the procedure date: _____

Do you have medical implants of ANY type? YES NO

What type of implants? _____

Have you ever been diagnosed with cancer? YES NO

If YES, please list the type and form of treatment: _____

Do you or have you had **any** incidental or prolonged exposure to metal or the metal industries due to employment, an accident or for any other reason? YES NO

If answered YES, please explain: _____

Have you had an orbital x-ray for MRI clearance? YES NO

Have you had any relevant x-rays or other testing done prior to today's exam? YES NO

If YES, when and where were the prior tests performed and what were the results? _____

Do you have asthma? YES NO

Do you have any kidney disease or dysfunction? YES NO

Do you have diabetes? YES NO

If YES, what diabetes medications are you currently taking? _____

Which doctor manages your diabetes? _____ Phone #: _____

I attest that the above information is correct and true to the best of my knowledge. I have read and understood the entire contents of this form and have had the opportunity to ask questions regarding its requested information.

Signature (Patient or Legal Guardian): _____ Date: _____

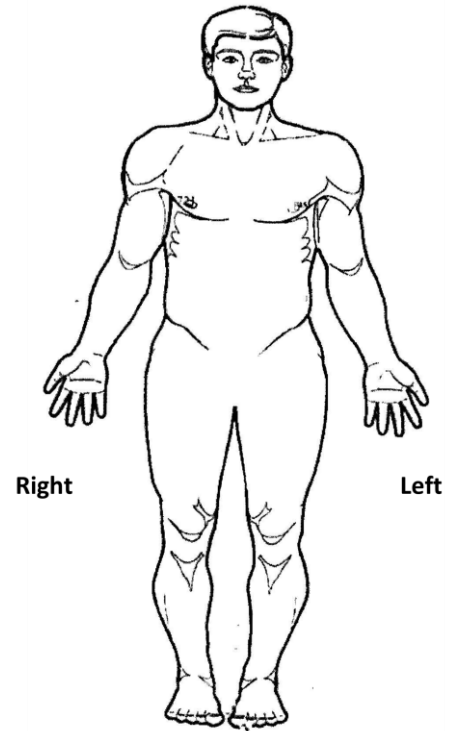
Please check this box if you or the dependent whom you are signing this paperwork for have any special needs. []

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

YES	NO	
_____	_____	Cardiac Pacemaker
_____	_____	Aneurysm Clip(s)
_____	_____	Implanted cardiac defibrillator
_____	_____	Neurostimulator
_____	_____	Any type of biostimulator
_____	_____	Type: _____
_____	_____	Any type of internal electrode(s) including:
		Pacing wires
		Cochlear implant
_____	_____	Other: _____
_____	_____	Implanted Insulin pump
_____	_____	Swan-Ganz catheter
_____	_____	Halo vest or metallic cervical fixation devices
_____	_____	Any type of electronic, mechanical, or magnetic implant
_____	_____	Type: _____
_____	_____	Hearing Aid
_____	_____	Any type of intravascular coil, filter, or stent
		(e.g., Gianturco coil, Gunther IVC filter, Palmaz stent, etc.)
_____	_____	Implanted drug infusion device
_____	_____	Any type of foreign body, shrapnel, or bullet
_____	_____	Heart valve prosthesis
_____	_____	Any type of ear implant
_____	_____	Penile Prosthesis
_____	_____	Orbital/eye Prosthesis
_____	_____	Any type of implant held in place by a magnet
_____	_____	Any type of surgical clip or staple(s)
_____	_____	Vascular access port
_____	_____	Intraventricular shunt
_____	_____	Artificial limb or joint
_____	_____	Dentures
_____	_____	Diaphragm
_____	_____	IUD
_____	_____	Pessary
_____	_____	Wire Mesh
_____	_____	Any implanted orthopedic item(s) (e/g/, pins, rods, screws, nails, clips, plates, wire, etc.)
_____	_____	Type: _____
_____	_____	Any other implanted item:
_____	_____	Type: _____
_____	_____	Tattooed eyeliner*

Please mark on the drawing the location of any metal inside your body.



*A small percentage of patients with tattooed eyeliner have experienced transient skin irritation in association with MRI. Therefore, you must decide if this slight risk warrants undergoing your examination. You may want to discuss this matter with your referring physician.

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature _____

RT Signature _____ Date: _____

RT Name _____