



All Florida Orthopaedic Associates

MR Procedure Screening

Name: _____ Date: _____

Sex M F Age: _____ Physician: _____

Patient #: _____ Date of Birth: _____ Height: _____ Weight: _____

Procedure: _____

Diagnosis: _____

Clinical History: _____

Y N

Have you ever had a surgical procedure of any kind?
If yes, please list all prior surgeries and approximate dates:

History of claustrophobia?

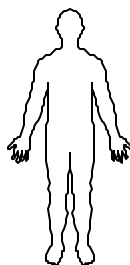
Have you ever been injured by any metallic foreign body, e.g. bullet, shrapnel, etc.? If yes, please describe:

Have you ever had an injury to the eye involving a metallic object, e.g. metallic slivers, shavings, foreign body, etc. If yes, please describe:

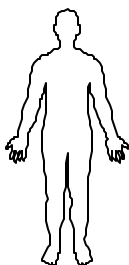
Do you have anemia or diseases that affect your blood?

Do you have a history of renal disease, seizure, asthma, or allergic respiratory disease?

Do you have any drug allergies? If yes, please list:



Right Left
Front



Left Right
Back

Using the following symbols, mark the areas on your body where you feel the described sensations. Include all affected areas.

- + Numbness
- Tingling
- * Weakness
- / Pain

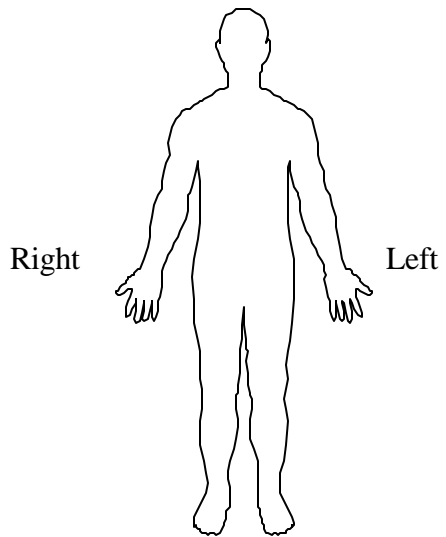
Y	N			
<input type="checkbox"/>	<input type="checkbox"/>			Have you ever had a reaction to a contrast medium used for MRI or CT?
<input type="checkbox"/>	<input type="checkbox"/>			Are you or do you suspect that you are pregnant?
<input type="checkbox"/>	<input type="checkbox"/>			Are you breast feeding?
<input type="checkbox"/>	<input type="checkbox"/>			Are you taking oral contraceptives or receiving hormone treatment?
<input type="checkbox"/>	<input type="checkbox"/>	Post-menopausal?		Last menstrual period:_____

Pertinent Previous Studies:

Procedure	Body Part	Date
X-rays		_____
Computed Tomography (CT)		_____
Ultrasound		_____
Nuclear Medicine		_____

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:

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm clip(s)
<input type="checkbox"/>	<input type="checkbox"/>	Implanted cardiac defibrillator
<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulator
<input type="checkbox"/>	<input type="checkbox"/>	Any type of biostimulator
		Type:
		Any type of internal electrodes(s)
		including:
<input type="checkbox"/>	<input type="checkbox"/>	- Pacing Wires
<input type="checkbox"/>	<input type="checkbox"/>	- Cochlear Implant
<input type="checkbox"/>	<input type="checkbox"/>	- Other (specify):
<input type="checkbox"/>	<input type="checkbox"/>	Implanted insulin pump
<input type="checkbox"/>	<input type="checkbox"/>	Swan-Ganz catheter
<input type="checkbox"/>	<input type="checkbox"/>	Halo vest or metallic cervical fixation device
<input type="checkbox"/>	<input type="checkbox"/>	Any type of electronic, mechanical or magnetic implant. Type:
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid
<input type="checkbox"/>	<input type="checkbox"/>	Any type of intravascular coil, filter or stent (Gianturco coil, Gunther IVC Filter, Plamaz stent, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Implanted drug infusion device
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve prosthesis
<input type="checkbox"/>	<input type="checkbox"/>	Any type of ear implant



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

Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	Penile prosthesis
<input type="checkbox"/>	<input type="checkbox"/>	Orbital/eye prosthesis
<input type="checkbox"/>	<input type="checkbox"/>	Any type of implant held in place by a magnet
<input type="checkbox"/>	<input type="checkbox"/>	Any type of surgical clip(s) or staple(s)
<input type="checkbox"/>	<input type="checkbox"/>	Vascular access port
<input type="checkbox"/>	<input type="checkbox"/>	Intraventricular shunt
<input type="checkbox"/>	<input type="checkbox"/>	Artificial limb or joint
<input type="checkbox"/>	<input type="checkbox"/>	Dentures
<input type="checkbox"/>	<input type="checkbox"/>	Diaphragm
<input type="checkbox"/>	<input type="checkbox"/>	IUD
<input type="checkbox"/>	<input type="checkbox"/>	Pessary
<input type="checkbox"/>	<input type="checkbox"/>	Wire mesh
<input type="checkbox"/>	<input type="checkbox"/>	Any implanted orthopaedic items(s): (pins, rods, screws, nails, clips plates, Wire, etc.). Type:
<input type="checkbox"/>	<input type="checkbox"/>	Tattooed eyeliner or other tattoos
<input type="checkbox"/>	<input type="checkbox"/>	Body piercing

If any “yes” have been checked, then MRI may be contraindicated. The above information will be reviewed prior to your scan for a determination. You will need to remove eye make-up, dentures, hairpins, earrings, necklaces, watches, hearing aids and glasses.

We **strongly** recommend using the earplugs or headphones we supply for your MRI examination since some patients may find the noise levels unacceptable, and the noise levels may temporarily affect your hearing.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form, and agree to participate in the study.

Patient Name (Please Print)

Patient Signature

Date

Patient Social Security Number

MD/RN/RT's Name (Please Print)

MD/RN/RT's Signature