FINGER LAKES RADIOLOGY LLC

enhancing your view

MRI SCREENING FORM

Patient Name: _____ Date: _____

Sex: _____ Age: _____ Height: ___Ft.____Inches Weight :_____pounds

This questionnaire is designed to assist us in determining if it is safe for you to undergo a magnetic resonance imaging procedure. It is important that you answer all of the following questions. If you don't understand any question, please ask for assistance.

		Yes	No	Don't Know
1.	Do you have a pacemaker, wires, defibrillator, or implanted heart valves?	☐	☐	☐
2.	Have you ever had any head surgery requiring aneurysm clips?	☐	☐	☐
3.	Have you ever had any type of surgery?	☐	☐	☐
	Describe _____			
4.	Have you ever had a reaction to a contrast agent used for MRI, CT or X-ray?	☐	☐	☐
5.	Do you have any metal pins, joints, prosthesis, or metallic objects in or attached to your body?	☐	☐	☐
6.	Have you ever been exposed to metal fragments that could be lodged in your eyes or body?	☐	☐	☐
7.	Do you have a hearing aid, middle/inner ear prosthesis or dentures?	☐	☐	☐
8.	Do you have any type of electronic devises (stimulators or pumps) implanted in your body?	☐	☐	☐
9.	Do you have or have you ever had any tattoos, tattooed eyeliner, lip liner or body piercing?	☐	☐	☐
10.	Do you wear a transdermal patch (nitroglycerin or nicotine)?	☐	☐	☐
11.	Do you have a history of panic attacks or a fear of enclosed or narrow places?	☐	☐	☐
12.	Do you have any known drug allergies? _____	☐	☐	☐
13.	If you are a woman – are you pregnant or breastfeeding, or is it possible that you might be pregnant?	☐	☐	☐
14.	Is there any other item or device you believe we should know about prior to performing the procedure;			
	If yes, please describe: _____			

15. Why are you having a MRI? Did you have an injury? _____

16. Please list all medications that you are taking at this time: _____

*Co-payments are due at the time of service. If unable to keep appointment, kindly give 24 hour notice.

**Please be advised that if you have pre-medicated yourself prior to MRI, it is your responsibility to have a driver when you leave the procedure.____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform Finger Lakes Radiology if any metal fragments and/or devices that may be in my body and that by failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and, after consultation with a physician, elect to proceed with the MRI, I agree to release Finger Lakes Radiology from any and all liability.

Patient or Legal Representative Signature Date Print Name and Authority (if legal representative)

_____

Physician/Registered Nurse/Technologist Date Print Name and Title

_____

Witness or Interpreter Signature Date Print Name

196 North Street, Geneva, New York · 315-787-5399 · fax: 315-787-5391
info@fingerlakesradiology.com

Revised 11/24/15

SECTION A: HEALTH HISTORY

1. Briefly describe your general health:

2. Do you have any of the following (Please Circle) :

□High Blood pressure □Diabetes □Cancer □Kidney Disease Liver Transplant

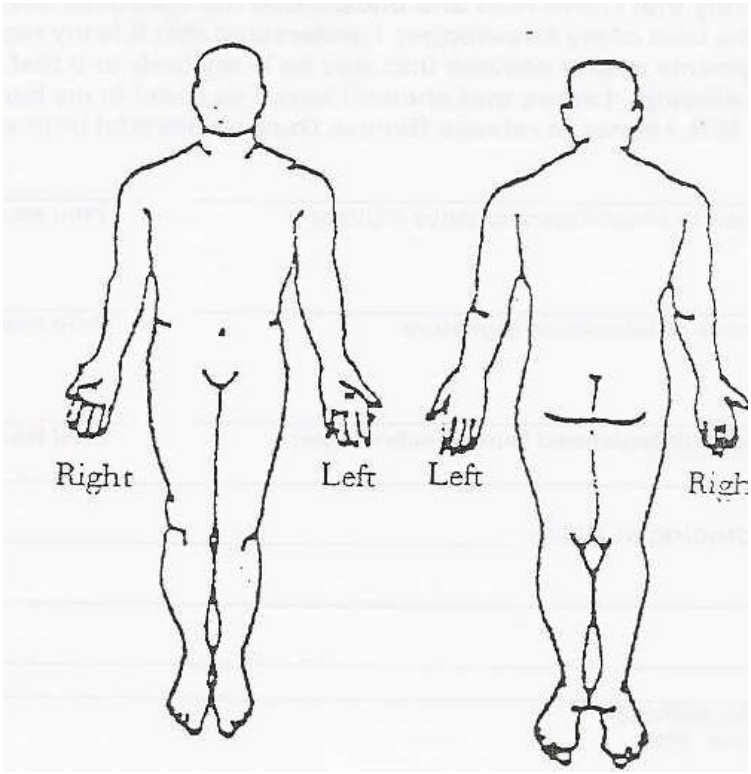
□Asthma □COPD □Kidney Transplant □ Sickle Cell Anemia

3. Do you smoke? □Yes □Former Smoker □Never Smoked

SECTION B: NECK AND SPINE PATIENTS ONLY

1. Do you have neck, low back, or thoracic pain? ____ If yes, how long have you had it? _____
2. Do you have arm or leg pain/numbness? _____ arm or leg?_____ For how long? _____ Which side? _____
3. Are you taking medication for your pain? _____ If yes, which medicine? _____
4. Have you ever had a Myelogram of your SPINE? _____
5. Have you ever had a CT or MRI scan of your SPINE? _____ If yes: location/facility _____ When? _____
6. Have you ever had spine surgery? ____ If yes, when? _____ At what facility was the surgery performed? _____
7. Did the surgery relieve the pain? _____ If yes, has the same pain recurred? _____

PLEASE SHADE IN THE AREAS THAT HURT:



Office Use Only

GFR:_____

Results Date:_____

Initials:_____

196 North Street, Geneva, NY 14456 · 315-787-5399 · fax:315-787-5391·
info@fingerlakesradiology.com