Date	Referring Physician	Technologist	Radiologist

Patient Name (Last / First)	Pt. ID No.	Sex ☐ M ☐ F	Weight lbs.	Date of Birth	Age	Scan Date

Home Phone No.	Work Phone No.	Body Area to be Scanned	Reason for Scan

Does your insurance company require pre-authorization for this procedure? ☐ Yes ☐ No | If yes, has this been done? ☐ Yes ☐ No | If yes, give pre-authorization number:

Person Giving Information ☐ Patient ☐ Other:

Has patient had prior surgery? ☐ Yes ☐ No If yes, date & what type: _____

List Allergies

Any previous pertinent studies? ☐ CT ☐ MRI ☐ X-RAYS

Is patient pregnant? ☐ Yes ☐ No ☐ Unsure LMP _____

Is patient claustrophobic? ☐ Yes ☐ No
If yes, patient may need to be sedated and have someone drive them home.

Is patient able to lie flat for 1 hour on hard surface? ☐ Yes ☐ No *If no, patient may require sedation.*

Yes	No	
☐	☐	Pacemaker
☐	☐	Neurostimulator or Tens Units
☐	☐	Brain Surgery Clips
☐	☐	Aortic Clips
☐	☐	Nitroglycerin Patches

Yes	No	
☐	☐	Heart Valve Surgery prior to 1964 (Starr Edwards Heart Valve)
☐	☐	Middle Ear Prosthesis / Cochlear Implant
☐	☐	Metal in Eye (Present or past hx of metal, i.e.: iron worker, welder, metal sculpturer, etc.) If yes, perform waters x-rays to clear for metal.

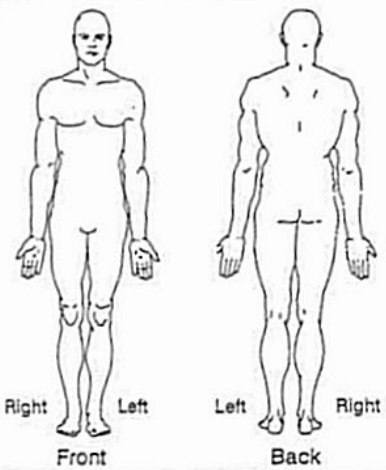
☐ None of the Above

Contraindications — If any of the above items are marked Yes, the scan cannot be performed

Yes	No		Yes	No		Yes	No	
☐	☐	Any Metal Fragments in or on Body	☐	☐	Shrapnel	☐	☐	Artificial Limbs
☐	☐	Surgical Clips	☐	☐	Metal Hip Prosthesis	☐	☐	Dentures or any Removable Dental Work
☐	☐	Metallic IUD	☐	☐	Prosthetic Bladder Control	☐	☐	Epilespy / Seizures
☐	☐	Bone Fracture Screws	☐	☐	Hearing Aid	☐	☐	Eye Makeup / Eye Tattoo
☐	☐	Metal Rods or Plates	☐	☐	Insulin Pump	☐	☐	Vascular Stents
☐	☐	Harrington Rods	☐	☐	Shunt			
☐	☐	Wire Sutures	☐	☐	Eye / Lens Implants	☐		None of the Above

WARNING **This equipment must not be taken into the magnetic room. Damage to the equipment, MRI system and PERSONAL INJURY COULD RESULT. *Do not enter the scan room with any of these items:***

☐ Glasses	☐ Keys	☐ Safety Pins	☐ Hairpins/Barrettes
☐ Belt Buckle	☐ Wallet/Money Clip	☐ Metal Zippers/Buttons	☐ Metal Bra Hooks
☐ Hearing Aid	☐ Pens/Pencils	☐ Removable Dental Work	☐ Bra and Girdle Underwire Support
☐ Jewelry	☐ Coins	☐ Shoes	
☐ Watch	☐ Pocket Knife	☐ Magnetic Strip Cards (Credit cards, bank cards)	☐ Sanitary Belt



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

\+ Numbness

— Tingling

* Weakness

/ Pain

I understand and have answered all the above eligibility questions.

Patient Signature	Date

PATIENT IDENTIFICATION