

THE FOLLOWING ITEMS MAY BE HARMFUL TO YOU DURING YOUR MRI SCAN OR MAY INTERFERE WITH THE MRI EXAMINATION.

You must provide a Yes or No for every item. Please indicate if you have or have had any of the following:

Yes No

- Any type of electronic, mechanical, or magnetic implant. (Type _____)
- Cardiac pacemaker.
- Aneurysm clip(s).
- Implanted cardiac defibrillator.
- Neurotransmitter.
- Biostimulator (Type _____)
- Any type of internal electrode(s) or wires(s).
- Cochlear implant.
- Hearing Aid.
- Implanted drug pump (e.g. insulin, Baclofin, chemotherapy, pain medicine)
- Halo vest
- Spinal Fixation device
- Spinal Fusion procedure
- Any type of coil, filter or stent (Type _____)
- Any type of metal object (e.g. shrapnel, bullet, or BB)
- Artificial heart valve
- Any type of ear implant
- Penile implant
- Artificial eye
- Eyelid spring
- Any type of implant held in place by a magnet (Type _____)
- Any type of surgical clip or staple
- Any I.V. access port (e.g. Broviac, Port-a-Cath, Hickman, Picc line)
- Medication patch (e.g. Nitroglycerine, Nicotine)
- Shunt
- Artificial limb or joint (What and where _____)
- Tissue expander (e.g. breast)
- Removable dentures, false teeth or partial plate
- Diaphragm, IUD, Pessary (Type _____)
- Surgical mesh. (Location _____)
- Body Piercing (Location _____)
- Wig, Hair Implants
- Tattoos or tattooed eyeliner
- Radiation seeds (e.g. cancer treatment)
- Any implanted items (e.g. pins, rods, screws, nails, plates, wires)
- Any hair accessories (e.g. bobby pins, barrettes, clips)
- Jewelry
- Any other type of implanted item (Type _____)

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.

Patient Signature _____

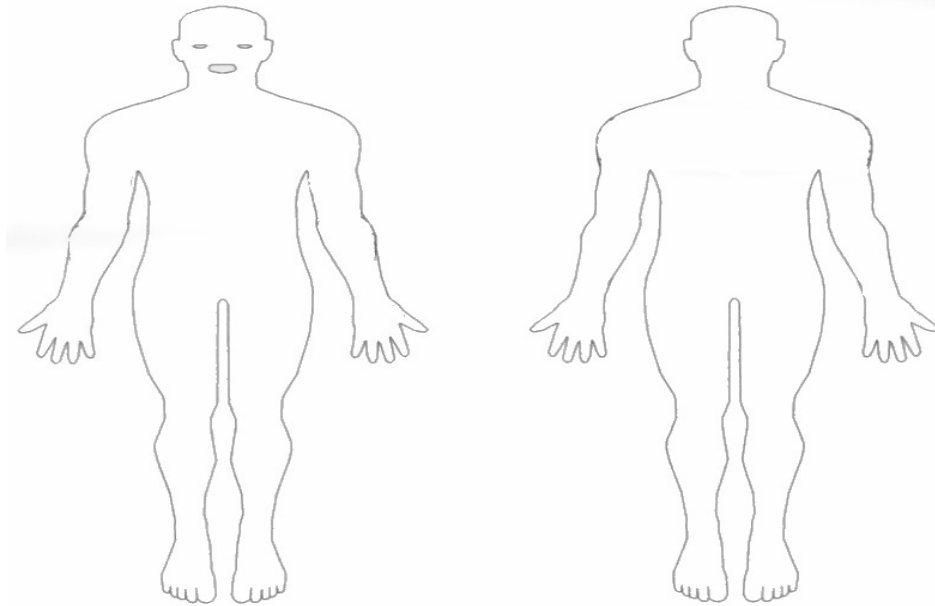
MD/RN/RT Signature _____ Date _____

WELCOME TO OPEN MRI OF ORLANDO

Imaging Number: _____ **Date of Injury:** _____
Type of Injury: MVA _____ W/C _____ Other _____ If other explain: _____
Claustrophobic? Yes or No **Type of Music preferred:** _____
Patient Name: _____ **SS#:** _____
Birth Date: ___/___/___ **Age:** _____ **Weight:** _____ lbs **Height:** ___' ___" **Male/Female**
Referring Physician: _____ **Contact Person:** _____
Date & Time of Follow up Appointment: _____ (with Referring Physician)
Reason(s) for this Exam: (symptoms- brief history- length of time)

Mark the area(s) where you feel your symptoms.

///////= Stabbing pain; 0000= tingling; XXX= Burning; AAA= Aching;
TTTT= Throbbing; SSSS=Shooting; DDDD=Dull; NNN= Numb.



Prior similar exams? When? Where? (e.g. X-rays, MRI, CT, LAB, Ultrasound)

Prior Surgeries? _____

1. **Do you have or have you had a cardiac pacemaker?** Yes or No
2. **Do you have any Cerebral (Brain) Aneurysm Clips?** Yes or No
3. **Do you have any metallic implants in your body?** Yes or No
If yes, Where? _____ How long? _____
4. **Have you ever performed metal grinding or welding?** Yes or No

5. **Have you ever had a metallic foreign object in your eye?** Yes or No
6. **Allergies** Yes or No If yes, please list: _____
7. **Do you have high blood pressure?** Yes or No
8. **Medications taken today?** Yes or No What time? _____
 Medication: _____ Dosage: _____
 Medication: _____ Dosage: _____
9. **Do you have a history of cancer?** Yes or No What type? _____
 Chemotherapy? Yes or No Radiation? Yes or No
10. **Do you have numbness in your: Hands or Feet ?** Right side/ Left side
11. **Do you have shooting pain down your: Arms or Legs ?** Right side/ Left side
12. **Is there any possibility you may be pregnant at this time?** Yes or No

Signature _____ Date _____
 Witness _____ Date _____

OFFICE STAFF ONLY

*****Technologist Notes Only*****

Type of Exam(s) performed: MRI _____ X-Ray _____

History: _____

Contrast? Yes or No Amount _____ Site _____ **Sedation?** Yes or No **Type:** _____

Sequences: _____

