

MRI & IMAGING CENTER MR INFORMATION FORM

Name _____ Date of Birth _____ Sex ____ Weight _____

Requesting Physician _____ Family Physician _____

****Please list the date of onset for your injury or illness: _____****

What problems or symptoms are you experiencing that your doctor ordered this test? _____

Any recent trauma to the affected area? _____

Have you ever had cancer, if so please specify _____

Please list any previous testing for this condition and location of facility: _____

Are you being treated for any kidney disease, renal insufficiency or renal failure? Y / N _____

THE FOLLOWING ITEMS CAN INTERFERE WITH MR IMAGING, SOME CAN EVEN BE HAZARDOUS TO YOUR SAFETY.

PLEASE LET US KNOW IF YOU HAVE ANY OF THESE ITEMS:

Y / N	Cardiac Pacemaker /Lead Wires	Y / N	Hearing Aids
Y / N	Stent or Wire in Blood Vessel/Shunts	Y / N	Cochlear, Otologic or Other Ear Implant
Y / N	Artificial Heart Valves	Y / N	Prior Gunshot Wound
Y / N	Brain Aneurysm Clips	Y / N	Facial Injury from Metal
Y / N	Prosthesis (Orbital, Joint, or Penile)	Y / N	Welding/Metal Silvers/Shavings in Eyes
Y / N	Metallic Implants /or Body Piercings	Y / N	IUD / Pessary
Y / N	Artificial Limbs or Joints Replaced	Y / N	Pregnant Or Breast Feeding
Y / N	Insulin or Drug Infusion Pump	Y / N	Transdermal Patch
Y / N	Neurostimulators	Y / N	Other, specify below if yes

Females Only: Date of Last Cycle _____

I have answered these questions to the best of my knowledge and understand the information presented to me.

A report will be generated to your ordering physician within 24-48 hours of your findings. Your physician then will advise you of the results.

Patient Signature _____ Date _____

Technologist Signature _____ Date _____

For Technologist : Did patient receive CD or FILMS?