MIDLANDS ORTHOPAEDICS AND NEUROSURGERY MRI HISTORY AND SCREENING

Name: _____ Date: _____

Sex: M F Height: _____ Weight: _____ Age:_____

Body Part to be examined: _____

Have you taken sedation/alcohol today to relax you for this procedure? Yes/No If so, what? _____
If yes, do you have someone to drive you home? Yes/No

List any DRUG allergies: _____
List any medication you are PRESENTLY taking:

_____

List any previous Surgeries:

_____

List any prior imaging studies you have had on this body part: _____

Yes No Cardiac Pacemaker	**Yes No** Ear Surgery: Cochlear Implant/Stapes Prosthesis/Hearing aid
Yes No Heart Surgery/Heart Valve	**Yes No** Vascular Access Port/Catheter
Yes No Implanted Cardiac Defibrillator (ICD)	**Yes No** Metal mesh implants/wire sutres/wires staples or Clips/Internal electrodes
Yes No Brain Aneurysm Clips/Brain Surgery	**Yes No** Electrical/Mechanical/Magnetic Implants
Yes No Shunts/Stents/Filters/Intravascular Coil	**Yes No** Implanted Drug Infusion pump/Medication patch
Yes No Eye Surgery/Implants/Spring/Wires/Retinal Tack	**Yes No** Tissue Expander (Eg. Breast)
Yes No Dentures/Partials/Dental Implants	**Yes No** Are you pregnant? **Yes No** IUD? Date of last menstrual period _____
Yes No Orthopedic pins/screws/rods/joints prosthesis	**Yes No** Tattoos/Permanent Make-up/Body Piercing/Patches
Yes No Neurostimulator/Biostimulator	**Yes No** Injury to the eye involving metal or metal shavings
Yes No History of Cancer or Tumor	**Yes No** Gunshot wounds/Shrapnel/BB
Yes No Previous Back/Neck surgery	**Yes No** Do you have pins in your hair/clothes/hair extensions/Hair pieces/Wig

MRI Contrast History ◯ Not applicable to this exam	
Yes No Have you ever had MRI Contrast?	**Yes No** Do you have history of Hypertension?
Yes No Did you have any kind of reaction?	**Yes No** Do you have history of Respiratory disease?
Yes No Are you breast feeding at this time?	**Yes No** Do you have diabetes?
Yes No Do you have history of renal disease?	**Yes No** have you ever had severe hepatic disease, liver transplant or pending liver transplant?

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time and I give consent to have a contrast agent administered to me if needed for proper diagnosis of my procedure. I acknowledge that I am aware of the possibility of side effects with contrast and I have had the opportunity to ask questions related to this form. I have had the opportunity to ask questions regarding the MRI procedure and I understand the information presented to me.

_____ _____ _____
Patient/Parent/Legal guardian MRI Technologist Signature Date

FOR TECHNOLOGIST USE ONLY

Type of Contrast: _____ **Contrast Temperature:** _____

Lot Number: _____ **Expiration Date:** _____

Type of Injection: _____ **Amount:** _____