



The Alpine Clinic

MRI Screening Form

Name: _____ DOB: _____ Sex: F M
 Phone: _____ Insurance Type: _____ Weight: _____
 Ordering Physician: _____ Ordering Physician Phone: _____
 Primary Care Physician: _____ Primary Care Physician Phone: _____

Type of Exam: MRI MRA Specify Body Part: _____ Left Right

Please list symptoms: _____

How long have you had symptoms? _____

Yes No Was there an injury that caused your symptoms? _____

Yes No Have you had surgery on the specific body part? Date _____

Attention patients and/or family members: The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body that can interfere with your scan or be dangerous to you. So to ensure your safety, PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY:

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker, Wires or Defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant or possibly pregnant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear Implants/ Internal Hearing Aid | <input type="checkbox"/> Yes <input type="checkbox"/> No Non Removable Electronic Device (?Tens) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Brain / Aneurysm Clips | <input type="checkbox"/> Yes <input type="checkbox"/> No Implants with magnets anywhere |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Orthopedic Hardware | <input type="checkbox"/> Yes <input type="checkbox"/> No Penile Prosthesis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Metal Shrapnel, fragments or bullets | <input type="checkbox"/> Yes <input type="checkbox"/> No Diaphragm or intrauterine device |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cataract or Eye implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Foil Nitroglycerine or Nicotine patches |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Coil, Filter, or wire in blood vessel | <input type="checkbox"/> Yes <input type="checkbox"/> No Silver Wound Dressing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Limb or Joint | <input type="checkbox"/> Yes <input type="checkbox"/> No Ear or body piercings |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoos or Tattooed eyeliner | <input type="checkbox"/> Yes <input type="checkbox"/> No False teeth, retainers, or magnetic braces |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Are you Breast feeding? | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex Allergy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin Pump | <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted Catheter, tube or Shunt |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have Diabetes? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had an MRI before? | <input type="checkbox"/> Yes <input type="checkbox"/> No Are you Claustrophobic? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been a metal worker? | |

Yes No Have you always worn eye protection when exposed to metal working?

Yes No Have you ever had an injury in the face or eye with a metallic object? Date _____

Yes No History of any cancer? Type: _____

Yes No Have you ever had a colonoscopy? When _____ Where _____

Yes No Have you had surgery in the past 8 weeks? Date _____ Where _____

Please List all surgical procedures with dates: _____

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the content of this form. I authorize MRI personnel to access all pertinent medical information necessary to perform this exam.

Signature (parent/Guardian) _____ Date: _____

MUSIC IS AVAILABLE TO LISTEN TO DURING YOUR EXAM. PLEASE FEEL FREE TO BRING A CD OR IPOD IF YOU WOULD LIKE. ☺

