Summerlin
IMAGING CENTER
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Jacksonville Diagnostic Imaging
Gainesville Diagnostic Imaging

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Patient Name:		MR#:	
Date of Birth:		Accession #:	
Referring MD:		Date of Study:	

Describe your problem & how long have you had these symptoms.

_____

_____

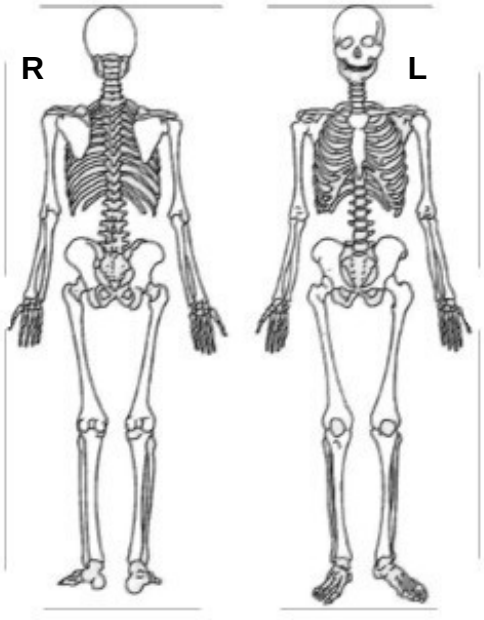
Are your symptoms the result of an injury? ☐ Y ☐ N If yes, date of injury _____
Please describe the injury. _____
Have you had surgery for this problem? ☐ Y ☐ N If yes, when? _____
Please list type of surgery _____
Have you had any other tests for this problem? _____
Name of facility where prior studies were performed _____

Myelogram? ☐ Y ☐ N **CT Scan? ☐ Y ☐ N** **MRI Scan? ☐ Y ☐ N**

Is it possible you are pregnant? ☐ Y ☐ N Are you nursing an infant? ☐ Y ☐ N

Please circle your symptoms.

Neck Pain	☐ right	☐ left
Arm Pain	☐ right	☐ left
Arm Numb	☐ right	☐ left
Arm Weak	☐ right	☐ left
Leg Pain	☐ right	☐ left
Leg Numb	☐ right	☐ left
Leg Weak	☐ right	☐ left



Drug Allergies (please list): _____

Food Allergies: _____

Surgeries: _____

_____

Pre-contrast Vitals: _____

Post contrast Vitals: _____

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Patient Name: **Date of Birth:**

Procedure: **Height:** _____ **Weight:** _____

TO **OUR PATIENTS** and **ACCOMPANING FAMILY MEMBERS**: The MRI room contains a very strong magnet. Before you are allowed to enter, we **MUST** know if you have any metal in your body. Some metal objects/implants can interfere with your scan or may even be harmful, so **PLEASE** answer the following questions **CAREFULLY** and **HONESTLY.** If you have a question regarding ANYTHING on this form, PLEASE ***DO NOT HESITATE TO ASK!***

DO YOU HAVE ANY OF THE FOLLOWING?

A **cardiac pacemaker** **or** **defibrillator**(ICD)? **If yes STOP**	☐ Yes ☐ No
Have you ever had an injury to your eye involving metal/metal shavings or slivers?	☐ Yes ☐ No
Are you a welder /grinder? **If yes**, perform orbit xrays. (No script needed)	☐ Yes ☐ No
Aneurysm clips/coils/ programmable shunt? **If yes**, provide the implant card or report.	☐ Yes ☐ No
Ear/eye implants, springs, wires, eyelid weights? **If yes**, provide the impant card or report	☐ Yes ☐ No
Insulin pump? **If yes**, will need to be disconnected prior to MRI	☐ Yes ☐ No
Pain pump? **If yes**, provide implant card or report. Need to f/u w/ physician to check the pump	☐ Yes ☐ No
Bone fusion /Bone growth stimulator? **If yes**, provide implant card or report	☐ Yes ☐ No
Neuro/spinal cord stimulator, internal electrodes or wires? **If yes**, provide implant card or report	☐ Yes ☐ No
Anything magnetic/electronic implanted in your body? **If yes**, provide documentation	☐ Yes ☐ No
Any metallic clips, coils, filters or stents? **If yes,** provide implant card or report	☐ Yes ☐ No
Artificial heart valve? **If yes**, provide documentation	☐ Yes ☐ No
Swan-ganz catheter or thermos-dilation catheters?	☐ Yes ☐ No
Any type of prosthesis (penile, artificial limbs, eye, etc)?	☐ Yes ☐ No
Shunt (spinal or intraventricular)?	☐ Yes ☐ No
Vascular access port and/or catheter?	☐ Yes ☐ No
Wire mesh implanted?	☐ Yes ☐ No
Tissue expander (e.g. breast)?	☐ Yes ☐ No
Surgical staples, clips, or metallic sutures?	☐ Yes ☐ No
Joint replacement (hip, knee, shoulder, etc)?	☐ Yes ☐ No
Bone/joint pens, screws, nails, wires, plates, etc?	☐ Yes ☐ No
Body piercing jewelry (MUST be removed unless plastic /silicone)?	☐ Yes ☐ No
Medication patches (e.g., nicotine, nitroglycerine, fentanyl, etc.)?	☐ Yes ☐ No
Any metallic fragments/foreign body (shrapnel, bullets, BBs, etc)?	☐ Yes ☐ No
IUD, diaphragm, or pessary?	☐ Yes ☐ No
Removal dental item (e.g., partial or dentures, retainer)?	☐ Yes ☐ No
Tattoo or permanent makeup?	☐ Yes ☐ No
Hearing aids (MUST be removed before entering MRI scan room)?	☐ Yes ☐ No
Dental implants (MUST be at least 6 wks post op)?	☐ Yes ☐ No
Are you claustrophobic?	☐ Yes ☐ No
Have you swallowed a video capsule within the last 30 days?	☐ Yes ☐ No
Have you had any surgeries in the last 6 weeks?	☐ Yes ☐ No

I attest that the answers I have provided on this form are correct and tuneful 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 information on this form.

Patient Signature: _____ Date: _____

Technologist: _____ Date: _____