CONE HEALTH
The Network for Exceptional Care

MRI SPINE
PATIENT HISTORY AND SCREENING

Name: _____
Referring Physician:_____

Please explain your present complaint or problem in detail:_____
_____
How long have you had this problem?_____

My problem affects my: (Please circle any/all extremities involved)
Left arm Left leg
Right arm Right leg

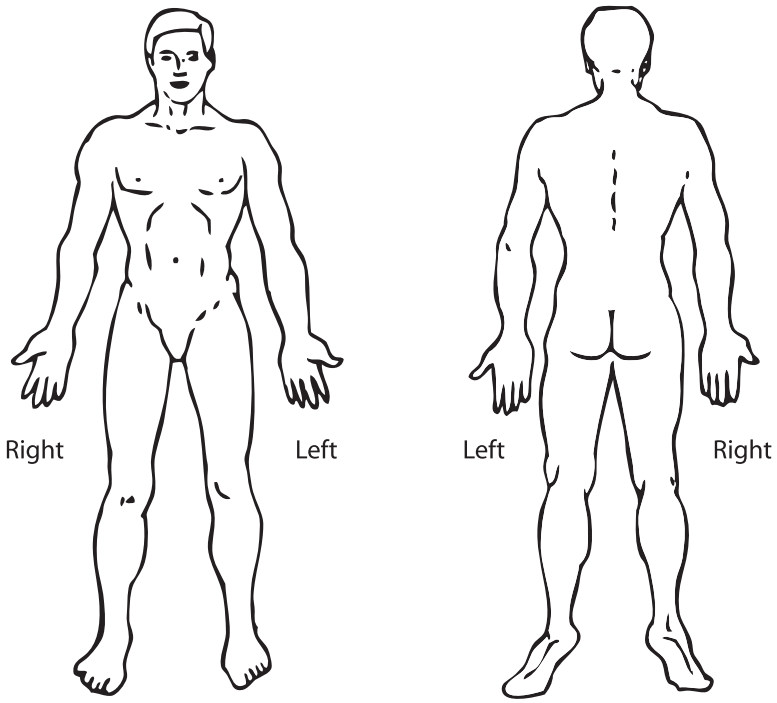
Please check if you have any of the following and where:

Weakness: _____ Bowel changes:_____
Numbness:_____ Bladder changes:_____
Pain:_____ Fever:_____
Spine surgery:_____ Steroid therapy:_____
Cancer:_____ Radiation: _____

Have you had any previous studies of the body part being scanned today? ☐No ☐Yes

Where and when? _____
Are you on dialysis? ☐No ☐Yes Do you have Sickle Cell? ☐No ☐Yes

On the drawings below, please shade the areas of your problems:



(please turn over)

PATIENT MRI SAFETY SCREENING FORM

Name:_____ Weight:_____

Date of Birth:_____ Last menstrual period:_____ N/A☐

Please check any that apply:
Possibly pregnant?☐Yes Claustrophobic (afraid of closed in areas)? ☐Yes
Have you **EVER** worked around metal grinding/filing or welding? ☐Yes
Have you **EVER** had metal particles in your eyes? ☐Yes

Please list any surgeries you have had:_____
_____

Please list any known allergies to latex, tape or drugs that you have:
_____

Please list current medications : _____
_____
_____

Do you have history of renal disease or dialysis? ☐No ☐Yes
Do you have history of High Blood Pressure? ☐No ☐Yes
Do you have history of diabetes? ☐No ☐Yes
Do you have Sickle Cell? ☐No ☐Yes
Do you have history of liver disease? ☐No ☐Yes
Do you have history of asthma? ☐No ☐Yes

The following items ***can*** interfere with MR imaging and ***can*** be hazardous to your safety. Please check appropriate items & notify the Technologist if you have any of the following:

_____Cardiac pacemaker	_____Hearing aids	_____Brain clips
_____Cochlear implants	_____Aortic clips	_____Shunts
_____Carotid clips	_____Joint replacements	_____Neurostimulators (Tens)
_____Harrington rod	_____Heart valve replacements	_____Bone or joint pins
_____Insulin pump	_____Prosthesis	_____Electrodes
_____Wire sutures	_____Metal mesh	_____Shrapnel
_____Metal plates	_____Dental/teeth work with magnets	
_____Medication patch	_____Therapeutic Magnets or screws, nails or metal rods	

_____Other (please list) _____

DO NOT ENTER THE SCANNING ROOM WITH ANY OF THE FOLLOWING ITEMS:
Hearing aids, Magnetic strip cards (credit cards, bank cards), Jewelry, Hairpins/barrettes, Glasses, Watch, Wallet/Money Clip, Pocket knife, Safety pins, Pens/pencils, Phone/pager, Keys, Coins

**** Lockers will be provided to lock patient valuables ****

I have reviewed and confirmed that the above information is complete to the best of my knowledge:

Pt. Signature: _____ **Date:**_____

Please turn form over for additional information*****

MRI Technologist has interviewed patient: _____Tech
IV angiocath started: _____ RN/Tech
IV angiocath has been D/C: _____RN/Tech