Patient Name:_____ DOB:_____ Age:_____

MR#:_____

Music Station (Caldwell Location Only) #_____

Exam:_____ DOS:_____

Symptoms: _____

_____

PREFERRED LANGUAGE:_____

Patient has been informed of location: ___Yes ___No

Patient has been informed that he/she will need to change into scrubs do to possible metal in clothes: ___Yes ___No

Height: _____ Weight: _____

CALDWELL- Do you weigh an excess of 350 LBS? __ Yes __No

MERIDIAN- Do you weigh an excess of 600 LBS? __ Yes __No

Are you able to ambulate?_____

Any special needs: O2 (oxygen), a Wheelchair, etc.

_____

YES NO

☐ ☐ ARE YOU CLAUSTROPHOBIC? IF SO ANSWER THE FOLLOWING

*DID YOU SELF MEDICATE?*_____

TYPE OF MEDICATION: _____

SURGERY (of body part we are Scanning):
DATE:_____
FACILITY:_____

IMPLANTED GLUCOSE MONITOR? __Yes __No –
If yes need to schedule exam on day the monitor is going to be replaced

Any Surgeries within the last 6wks? Type:_____
Where:_____

Ear, Eye or Brain Surgeries? Type:_____
Prev. MRI (where)?_____

Please notify the center ***IMMEDIATLY*** if any of the following apply:
_____Pacemaker, _____Aneurysm Clips, _____Shrapnel, _____Stent:

- Location:_____
- Model#:_____
- Manufacturer:_____
- Facility:_____

_____Incident of Metal in the eye(s)

- Prior MRI since then? Yes/No
- If YES Where?_____
- If NO Where would you like order sent for XR or it can be done in Caldwell:_____

Have you ever had a reaction to MRI contrast? _____ Type: Swelling, Hives, Rash, Itchy Skin, Wheezing, Anaphylaxis

- List any known Allergies:_____

_____

Has there ever been a problem with medical staff starting an IV or drawing blood?_____

Meridian patients contrast exams:

- Labs within last 6 weeks? ___ Yes ___No
- If Yes where:_____
- If No Where would you like lab order sent or it can be done Caldwell at NO Charge

WARNING: Certain implants, devices or objects may be hazardous to you and/or may interfere with the MRI procedure. **DO NOT ENTER** the MRI system room or MRI environment if you have any questions or concern regarding an implant device or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MRI system room. **THE MRI MAGNET IS ALWAYS ON.**

YES NO

☐ ☐ ARE YOU CURRENTLY IN RENAL FAILURE OR ON DIALYSIS, HAVE KIDNEY PROBLEMS OR RENAL INSUFFICIENCY?

☐ ☐ ARE YOU DIABETIC?

☐ ☐ DO YOU OR HAVE YOU HAD A CARDIAC PACEMAKER?

☐ ☐ DO YOU HAVE AN IMPLANTED CARDIAC DEFIBRILLATOR?

☐ ☐ DO YOU HAVE AN IMPLANTED BIO STIMULATOR OR TENS UNIT?

☐ ☐ DO YOU HAVE OR HAVE YOU HAD A COCHLEAR (INNER EAR) IMPLANT?

Patient Name:_____ **DOB**_____ **MR#**_____

PLEASE INDICATE IF YOU NOW HAVE OR HAVE EVER HAD ANY OF THE FOLLOWING:

YES NO

- ☐ ☐ **SWAN-GANZ OR THERMODILUTION CATHETER**
- ☐ ☐ **ELECTRONIC IMPLANT/DEVICE**
- ☐ ☐ **MAGNETIC IMPLANT DEVICE**
- ☐ ☐ **IMPLANTED DRUG INFUSION DEVICE**
- ☐ ☐ **NEUROSTIMULATION SYSTEM**
- ☐ ☐ **INTERNAL ELECTRODES/WIRES**
- ☐ ☐ **BONE GROWTH/FUSION STIMULATOR**
- ☐ ☐ **TEMPERATURE FOLEY**
- ☐ ☐ **INFUSION OR PUMP FOR INSULIN**
- ☐ ☐ **EYELID SPRING/WIRE**
- ☐ ☐ **HEART VALVE PROSTHESIS**
- ☐ ☐ **EAR IMPLANT TYPE:** _____
- ☐ ☐ **RADIATION SEEDS OR IMPLANTS**
- ☐ ☐ **FILTER/COIL: LOCATION** _____
- ☐ ☐ **SPINAL/INTERVENTRICULAR SHUNT**
- ☐ ☐ **VASCULAR ACCESS PORT/CATHETER**

YES NO

- ☐ ☐ **SURGICAL STAPLES/CLIPS/SUTURES**
- ☐ ☐ **JOINT REPLACEMENT (HIP/KNEE/ETC.)**
- ☐ ☐ **ARTIFICIAL/PROSTHETIC LIMB**
- ☐ ☐ **PROSTHESIS (ANY TYPE)**
- ☐ ☐ **BONE OR JOINT PIN/SCREW/NAIL/PLATE**
- ☐ ☐ **ANY METALLIC FRAGMENT/FOREIGN BODY**
- ☐ ☐ **CANCER: TYPE/DATE:** _____
- ☐ ☐ **GI TRACT PROCDURE INVOLVING SURGICAL CLIPS: UPPER or LOWER**
- ☐ ☐ **TISSUE EXPANDER (E.G. BREAST)**
- ☐ ☐ **DENTURES OR PARTIAL PLATES**
- ☐ ☐ **HEARING AID (MUST REMOVE)**
- ☐ ☐ **MEDICATION PATCH (NICOTINE, NITROGLYCERINE, ETC.)**
- ☐ ☐ **TATTOOS OR PERMANENT MAKEUP**
- ☐ ☐ **BODY PIERCING JEWELRY- ALL PIERCINGS MUST BE REMOVED**
- ☐ ☐ **OTHER IMPLANT:** _____

FOR FEMALE PATIENTS

YES NO

- ☐ ☐ **ARE YOU PREGNANT OR EXPERIENCING A LATE MENSTRUAL PERIOD? DATE OF LAST PERIOD:** _____
- ☐ ☐ **ARE YOU POSTMENOPAUSAL?**
- ☐ ☐ **ARE YOU CURRENTLY USING AN IUD, DIAPHRAGM OR PESSARY?**
- ☐ ☐ **ARE YOU TAKING ORAL CONTRACEPTIVES OR RECEIVING HORMONAL TREATMENT?** _____
- ☐ ☐ **ARE YOU CURRENTLY BREAST FEEDING**

Have you ever had an IMAGING study of the SAME BODY PART we are examining today? NO_____ YES_____

IF YES PLEASE LIST: **Date** **Facility**

MRI _____

CT _____

US _____

XRAY _____

OTHER _____

Patient Name:_____ **DOB**_____ **MR#**_____

Please list all surgeries or operations you have had <u>in your lifetime</u>.

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

- **Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MRI system room.**
- **The MRI procedure you have been scheduled for may require the intravenous injection of a non-iodinated contrast solution. It is used to enhance the ability of MRI to facilitate diagnosis. While there are no known contraindications, mild side effects including nausea or slight headaches may occur. This solution is not the same used for CT scans or angiography**
- **I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.**

SIGNATURE OF PERSON COMPLETING FORM: _____
RELATIONSHIP: _____ DATE: _____