

Carolina Neurosurgery & Spine Associates, P.A. - MRI Patient Screening Form

Date / / Ordering Physician MRN

Name Last name First name Middle Initial Date of Birth MM / DD / YY Male/Female (circle one)

Age Height Weight lbs. Describe your symptoms:

(symptoms continued)

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? YES / NO (Please circle one)

If yes, please indicate:

Date / / Type of surgery

Date / / Type of surgery

2. Have you had prior diagnostic imaging study or examination (MRI, CT, X-ray, Ultrasound, etc.)? YES / NO

If yes, please list type of exam(s), body part, date of exam and facility:

3. Have you had an injury to the eye or any other part of the body involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? YES / NO

If yes, please describe:

For female patients:

4. Date of last menstrual period: / / Post menopausal? YES / NO

5. Are you pregnant or experiencing a late menstrual? YES / NO

Please indicate if you have any of the following (circle one):

- YES / NO Vascular access port and/or catheter YES / NO Metallic stent, filter, or coil YES / NO Cardiac pacemaker
YES / NO Artificial or prosthetic limb YES / NO Insulin or other infusion pump YES / NO Aneurysm clip(s)
YES / NO Implanted cardioverter defibrillator (ICD) YES / NO Medication patch (e.g. nicotine) YES / NO Body piercing jewelry
YES / NO Electronic implant or device YES / NO Shunt (spinal or intra-ventricular) YES / NO Dentures or partial plates
YES / NO Magnetically-activated implant or device YES / NO Tattoo or permanent makeup YES / NO Wire mesh implant
YES / NO Tissue expander (e.g., breast) YES / NO IUD, diaphragm, or pessary YES / NO Neurostimulation system
YES / NO Surgical staples, clips, or metallic sutures YES / NO Swan-Ganz or thermodilution catheter YES / NO Heart valve prosthesis
YES / NO Internal electrodes or wires YES / NO Joint replacement (hip, knee, etc.) YES / NO Eyelid spring or wire
YES / NO Bone growth/bone fusion stimulator YES / NO Bone/joint pin, screw, nail, plate, etc. YES / NO Radiation seeds or implants
YES / NO Cochlear, otologic, or other ear implant YES / NO Implanted drug infusion device YES / NO Spinal cord stimulator
YES / NO Any type of prosthesis (eye, penile, etc.) YES / NO Hearing aid (remove before entering MRI room) YES / NO Claustrophobia
YES / NO Breathing problem or motion problem YES / NO Other implant

Before entering the MRI room, you must remove ALL metallic objects including hearing aids, dentures, partial plates, keys, cell phone, beeper, eyeglasses, hair pins, barrettes, jewelry, watch, safety pins, paperclips, credit cards, pocket knife, cigarette lighter, and any other metal objects. Please consult the MRI Technologist if you have any questions or concerns BEFORE you enter the MRI room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the MRI procedure I am about to undergo.

I hereby authorize Carolina Neurosurgery & Spine Associates, P.A. to release insurance information to Charlotte Radiology for billing purposes associated with the interpretation /reading of my MRI examination. I understand that I will receive two separate charges for this procedure; one for the MRI examination and one for the interpretation/reading.

Signature Relationship to patient Date / /

Technologist Signature Date / / (Rev 6/8/2005)

Office Use Only

Exam: Diagnosis: Amount of Contrast (if used): ccs

Technologist Notes: