

Today's Date \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Physician Ordering MRI \_\_\_\_\_

Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Area to be scanned \_\_\_\_\_

Describe Injury or Problem \_\_\_\_\_

**Preferred testing location -**      Downtown Iowa Ortho      No preference      Other \_\_\_\_\_

**Incorrect or falsified information can cause serious injury including blindness, burns, and/or damage to implanted items.**

Yes     No    Have you ever had an injury to the **eye** involving a metallic object (e.g., metallic slivers, shavings, foreign body, etc.)

**Date of eye injury:** \_\_\_\_\_ **Describe injury:** \_\_\_\_\_

Yes     No    Have you ever been injured by any metallic foreign body (e.g., bullet, BB, shrapnel, etc.)?

**Date of metallic injury:** \_\_\_\_\_ **Describe injury:** \_\_\_\_\_

Yes     No    Have you ever had a surgical procedure or operation of any kind?

**If yes, please list all prior surgeries and approximate dates:** \_\_\_\_\_  
\_\_\_\_\_

Yes     No    Have you had any surgeries or colonoscopies in the past 6 weeks?

**If yes, please list:** \_\_\_\_\_

Yes     No    Do you have a history of cancer?

**If yes, when, where, what type?** \_\_\_\_\_

Yes     No    Do you anticipate any problem with lying on your back for at least 45 minutes?

Yes     No    Do you require assistance with any of the following: ambulation, walker, wheelchair or transferring from chair to table? **Circle all that apply.**

Yes     No    Do you have problems with claustrophobia (severe fear of small places)?

Yes     No    Have you ever had an MRI?

**If yes, when, where, what body part?** \_\_\_\_\_  
\_\_\_\_\_

Yes     No    Has the body part to be scanned ever had any of the following: x-ray, MRI, CT, or any other test? **Circle all that apply.**

**If yes, when, where?** \_\_\_\_\_  
\_\_\_\_\_

Yes     No    Do you have a history of renal disease, seizure, asthma, allergic respiratory disease, diabetes, high blood pressure, anemia, or other blood disease? **Circle all that apply.**

Yes     No    Do you have any allergies to drugs, iodine, or shellfish?

**If yes, please list:** \_\_\_\_\_  
\_\_\_\_\_

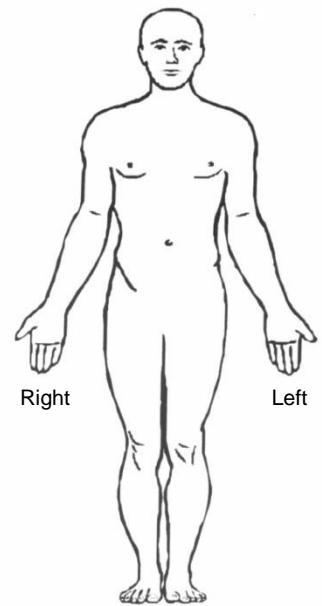
Yes     No    Have you ever had a reaction to a contrast medium used for MRI?

The following items may be hazardous or may interfere with MRI imaging by producing artifacts.

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

- Yes  No Females only: Are you pregnant or do you suspect that you may be pregnant?
- Yes  No Females only: Are you currently breast-feeding?
  
- Yes  No Cardiac pacemaker or defibrillator
- Yes  No Aneurysm clip(s)
- Yes  No Neurostimulator or biostimulator
- Yes  No Implanted leads or pacing wires
- Yes  No Ear Surgery or Hearing implant (including cochlear implant)  
**If yes, when and what type?** \_\_\_\_\_
- Yes  No Any type of coil, filter, stent, or shunt  
**Make and model:** \_\_\_\_\_
- Yes  No Swan-Ganz catheter or vascular access port
- Yes  No Any type of electronic or magnetic implant or medication pump
- Yes  No Any type of surgical hardware (plates, rods, etc.)
- Yes  No Any type of prosthesis (heart, limb, penile, etc.)
- Yes  No Eye implants or surgery: Lasik, Cataract, Other:  
 \_\_\_\_\_
  
- Yes  No Any type of surgical clip or staples
- Yes  No Drug patch
- Yes  No Body piercings
- Yes  No Dentures
- Yes  No Hearing aid
- Yes  No Tattoos or permanent make-up\*
- Yes  No Any implanted birth control?  
**If yes, what type?** \_\_\_\_\_
- Yes  No Any other implanted item  
**Type:** \_\_\_\_\_

Please mark on the drawing the location of your implants and/or metal injuries.



\*A small percentage of patients with tattoos have experienced transient skin irritation in association with MRI. Therefore, you must decide if this slight risk warrants undergoing your examination.

**PLEASE NOTE:** IF YES TO ANY OF THE ABOVE, PLEASE LIST THE PHYSICIAN'S NAME AND ADDRESS BELOW.

\_\_\_\_\_

\*During your MRI exam, we use noise levels that some may find unacceptable and can temporarily affect your hearing. Iowa Ortho provides headphones or ear plugs for each patient. You will also be given MRI safe clothing to change into before your exam.

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 verifies understanding and correctness of information.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Review \_\_\_\_\_ Date \_\_\_\_\_

Technologist Review \_\_\_\_\_ Date \_\_\_\_\_