



# Central Oregon Magnetic Resonance Imaging, LLC

## MRI PATIENT INFORMATION

- Central Oregon Radiology, Assoc., P.C.
- Cascade Medical Imaging, LLC - Redmond
- St. Charles Medical Center

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  Male  Female  
Last First MI Age

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Weight\*\* \_\_\_\_\_ Referring Physician: \_\_\_\_\_

In the interest of safety, we require that all patients change into a gown for their MRI exam. Additionally, you cannot bring any valuables into the scanning room (including credit cards) so the technologist will lock these up for you outside of the room.

**\*\* Your accurate weight is important! You may be weighed by the technologist prior to your exam. If your weight exceeds 350 lbs. an alternate study may be recommended by your physician.**

Briefly describe the problem(s) you are experiencing that made you see your doctor: \_\_\_\_\_

\_\_\_\_\_

Yes  No Have you had any surgery related to your current problem(s)?

What type of surgery? \_\_\_\_\_

Yes  No Do you have a personal history of cancer in any part of your body?

What part of your body and when was this diagnosis made? \_\_\_\_\_

PERTINENT PREVIOUS STUDIES:

WHEN and WHERE WERE THEY PERFORMED?

X-rays . . . . .

Computed Tomography also known as (CT) (CAT Scan) . . . . .

Ultrasound . . . . .

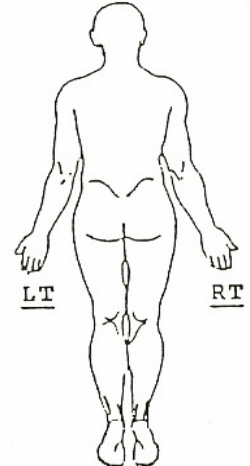
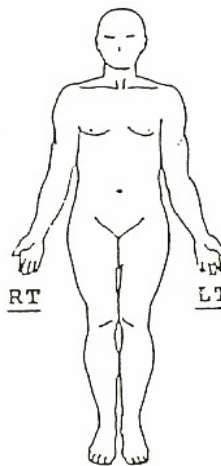
Nuclear Medicine . . . . .

MRI . . . . .

Please use this diagram to mark where you are feeling pain:

**PLEASE COMPLETE THE OTHER SIDE OF THIS FORM**

master form #17-mri patient info-pronto prt-white 7-27-07 cd



**THE FOLLOWING ITEMS MAY BE POTENTIALLY HAZARDOUS AND YOU MAY NOT QUALIFY FOR YOUR MRI SCAN. PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:**

- Yes  No Cardiac Pacemaker or Pacemaker Wires
- Yes  No Brain Aneurysm Clip(s)
- Yes  No Implanted Pumps/Electronic Devices
- Yes  No Neurostimulator or Mechanical Bone Growth Stimulator
- Yes  No Middle Ear Implant (Cochlear, Stapes, Hearing Aids)
- Yes  No Any Type of Intravascular Coil, Filter, Stent, Shunt or Heart Valves
- Yes  No Penile Prosthesis (Implant or Diaphragm/IUD)
- Yes  No Permanent (tattooed) Eyeliner
- Yes  No Do You Have Hemolytic or Sickle Cell Anemia?
- Yes  No Are You Pregnant or do You Suspect That You May Be Pregnant?
- Yes  No TENS Unit
- Yes  No Any Injury by Metallic Foreign body, Shrapnel or Bullet
- Yes  No Have You Ever Had A Job or Hobby Involving Sheet Metal Work, Grinding or Welding?
- Yes  No If Sedation/Relaxing Medication is Necessary - Do You Have Someone To Drive You Afterward

Patient Signature Consenting to Sedation/Relaxation Medication if Needed: \_\_\_\_\_

- Yes  No Are you on dialysis or do you have a history of kidney failure? (794.4)
- Yes  No Have you had a kidney removed?

Do you have **TWO** or more of the following conditions:

- Yes  No Are you a diabetic? (250.01) insulin dependent
- Yes  No Do you have a history of cancer or chronic illness? **If breast cancer which side:** \_\_\_\_\_
- Yes  No Do you have a history of heart disease? (V12.50 hx of)
- Yes  No Are you older than 65?
- Yes  No Do you have a history of long standing or poorly controlled hypertension?

MRI is usually a very safe medical procedure; however, MRI employs a strong magnet that can move metallic objects within patients. Such movement of metallic objects can have serious consequences for the patient. Please complete this screening form thoroughly to determine if it is safe for you to have an MRI

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. I hereby give my consent to having a Magnetic Resonance Imaging (MRI) scan.

Patient or Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Patient's Name: \_\_\_\_\_

Radiographer's Signature: \_\_\_\_\_

Radiographer - Screening Films Done for Questionable Foreign Body in Orbit(s)  Yes  No

Resonance Imaging, LLC that may not be approved or covered by my insurance company. Authorization is not a guarantee of payment. Claims payment will be based on member eligibility, medical necessity and benefits in effect at the time of service. I am agreeing to pay for these services personally if these services are not approved or covered.

Patient or Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_