



Central Oregon Magnetic Resonance Imaging, LLC

MRI PATIENT INFORMATION

Location of your exam

- 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

DOB: _____ Height _____ **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)?

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? _____

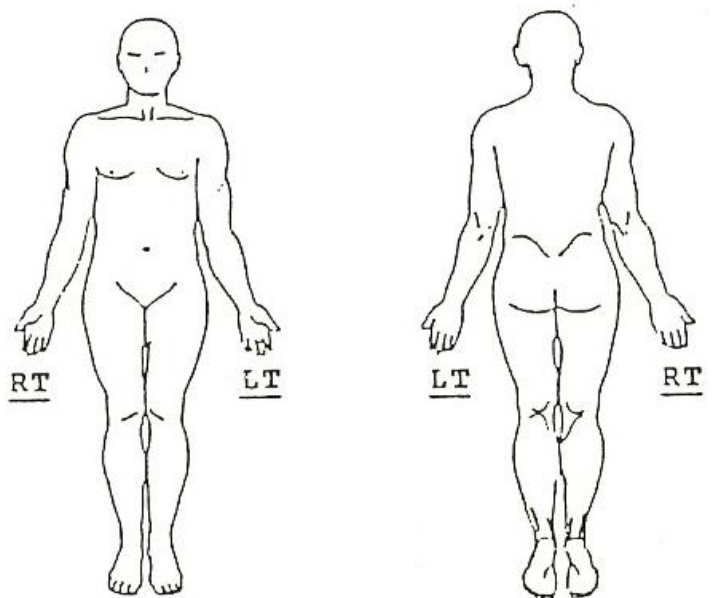
PERTINENT PREVIOUS STUDIES:

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



FOR OFFICE USE ONLY
PLACE MEDI-TAPE STICKER HERE

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 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 metal in your eyes? Example: From welding, grinding or other metal work?
- 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: _____

Signature

Do you have **ANY** of the following conditions:

- Yes No Are you on dialysis or do you have a history of kidney failure?
- Yes No Have you had a kidney removed?
- Yes No Are you a diabetic?
- Yes No Do you have a history of cancer treated with Chemotherapy?
- Yes No Do you have a history of heart disease?
- Yes No Are you older than 70?
- 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: _____

X

Date: ____/____/____

Print Patient's Name: _____

X

Radiographer's Signature: _____

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

I understand that I am requesting services from Central Oregon Radiology Assoc., P.C. and or Central Oregon Magnetic 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: _____

X

Date: ____/____/____

Witness Signature: _____

X

Date: ____/____/____