



108 Crossover Avenue, Suite E
Lowell, AR 72745
O. (479) 571-1004
F. (479) 571-5013

Patient Name _____ Date _____

S.S. # _____

Primary Insurance Information

Primary Insurance Name _____ Telephone _____

Insurance Address _____ Policy/ID # _____

City/State/Zip _____ Group # _____

Pre-Authorization # _____ Authorizing party _____

Name of Insured _____ Employer _____

Secondary Insurance Information

Secondary Insurance Name _____ Telephone _____

Insurance Address _____ Policy/ID # _____

City/State/Zip _____ Group # _____

Pre-Authorization # _____ Authorizing party _____

Name of Insured _____ Employer _____

Emergency Contact

Name _____ Telephone _____

Address _____ City/State/Zip _____

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ____/____/____ Patient Number _____

Name _____ Age ____ Height ____ Weight ____
Last name First name Middle initial

Date of Birth ____/____/____ Male Female Body part to be examined _____

Address _____ Telephone (home) (____) ____ - _____

City _____ Telephone (work) (____) ____ - _____

State _____ Zip Code _____ S.S. # _____

Reason for MRI and/or symptoms _____

Referring physician _____ Telephone (____) ____ - _____

1. Have you had prior surgery or an operation (eg. arthroscopy, endoscopy, etc.) or any kind? No Yes

If yes, please indicate the date and type of surgery:

Date ____/____/____ Type of surgery _____

Date ____/____/____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc?) No Yes

If yes, please list:

	Body part	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Ultrasound	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes

If yes, please describe: _____

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

If yes, please describe: _____

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

If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? No Yes

If yes, please list: _____

7. Are you allergic to any medication? No Yes

If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No Yes

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures? No Yes

If yes, please describe: _____

For female patients

10. Date of last menstrual period ____/____/____ Post menopausal? No Yes

11. Are you pregnant or experiencing a late menstrual period? No Yes

12. Are you taking oral contraceptives or receiving hormonal treatment? No Yes

13. Are you taking any type of fertility medication or having fertility treatments? No Yes

If yes, please describe: _____

14. Are you currently breastfeeding? No Yes



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

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

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clippers, tools, clothing with metal fastens & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have questions or concerns BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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

Signature of person completing form: _____ Date ____/____/____
Signature

Form completed by: Patient Relative Nurse _____
Print name Relationship to patient

Form information reviewed by: _____
Print name Signature

MRI Technologist Nurse Radiologist Other _____