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

Date _____/_____/_____ Ordering Physician_____ MRN_____

Name _____ Date of Birth ____/____/____ Age_____
Last name First name Middle Initial MM / DD / YY

☐ Male ☐ Female Height_____ Weight_____lbs.
(check one)

Describe your symptoms/pain:_____

(symptoms continued)_____

1. Have you had prior surgery on the area being scanned? ☐ **YES** ☐ **NO** If yes, please indicate below:

Date_____/_____/_____ Type of surgery_____

Date_____/_____/_____ Type of surgery_____

2. Have you had prior diagnostic imaging study or examination (MRI, CT) on the area being scanned today? ☐ **YES** ☐ **NO**

If yes, please list exam(s) and what facility performed at:_____

3. Have you had an injury to the eye or any other part of the body involving a metallic object or fragment? ☐ **YES** ☐ **NO**

If yes, please describe:_____

4. Have you had any prior history of Cancer? If yes, indicate what type and when?_____

5. Date of last menstrual period: _____/_____/_____ Post menopausal? ☐ **YES** ☐ **NO**

6. Are you pregnant or experiencing a late menstrual? ☐ **YES** ☐ **NO**

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Please indicate if you have any of the following (check YES or NO):

Yes	No		Yes	No		Yes	No	
☐	☐	Aneurysm Clip(s)	☐	☐	Programmable Shunt	☐	☐	Wire mesh implant
☐	☐	Cardiac pacemaker/Cardiac Defibrillator	☐	☐	NON-Programmable Shunt	☐	☐	Eyelid spring or wire
☐	☐	Metallic stent, filter, or coil	☐	☐	Bone/joint pin, screw, nail, plate, etc.	☐	☐	IUD, diaphragm, or pessary
☐	☐	Neuro-stimulation system	☐	☐	Joint replacement (hip, knee, etc.)	☐	☐	Metal Tissue expander (breast)
☐	☐	Internal electrodes or wires	☐	☐	Surgical staples, clips, or metallic sutures	☐	☐	Medication patch (e.g. nicotine)
☐	☐	Heart valve prosthesis	☐	☐	Clips(s) implanted during a colonoscopy	☐	☐	Tattoo or permanent makeup
☐	☐	Electronic/Magnetic implant or device	☐	☐	Baclofen/Insulin/Pain infusion pump	☐	☐	Body piercing jewelry
☐	☐	Electronic Bone/Spinal cord stimulator	☐	☐	Artificial prosthesis (eye, penile, limb, etc.)	☐	☐	Other implant:
☐	☐	Cochlear, or other ear implant				☐	☐	Claustrophobia

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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 .

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*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 8/31/11)

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Office Use Only

Exam: _____ Amount of Gadavist (if used): _____mL's

Technologist Notes: _____