



**Diagnostic
Imaging
Associates**
WWW.DIAXRAY.COM

MRI REQUEST FORM ♦ HEAD, SPINE, CHEST, ABDOMEN

Date: _____

This test may take up to 1 hour. For your comfort, please use our restroom facilities before your scheduled appointment.

Are you claustrophobic (afraid of tight spaces)? YES NO If yes, please notify the front desk immediately.

Name: _____ Birth Date / / Age: _____ Sex: M F Weight _____ lbs.
(First Middle Last)

Requesting Doctor: _____ Family Doctor: _____

Reason for this examination: _____

PATIENT HISTORY AND SCREENING:

A. Please list allergies _____

B. If female, is there a possibility of being pregnant? YES NO Last Menstruation Period? / /

C. Any previous radiologic exams (i.e., MRI, CT, Myelogram, Angiogram, X-Ray) of part of body being studied today?

Date, Type Of Exam and Where Performed?

1. _____ 2. _____

D. Have you had surgery other than dental surgery? If yes, please check location of surgery.

Brain Eye Sinus Ear Neck Chest Back Abdomen Extremities Other _____

Date, Type Of Surgery and Where Performed?

1. _____ 2. _____

E. Does your occupation expose you to metal fragments? YES NO (i.e. sheet metal shop, auto body shop)

F. Have you ever had metal fragments in your eye? YES NO

MEDICAL CONDITION

High Blood Pressure: YES NO

Diabetes: YES NO

Seizures: YES NO

OTHER MEDICAL CONDITIONS

Have you had a Tumor? YES NO If yes, specify type and location _____

Have you ever had CHEMOTHERAPY? YES NO

Have you ever had RADIATION THERAPY? YES NO If yes, when and at which hospital? _____

Do you take STEROID medication? YES NO

Have you had any STEROID injections? YES NO. If yes, when and where _____

Do you take ANTICONVULSANTS? (medicine for seizures) YES NO

Any other medication? _____

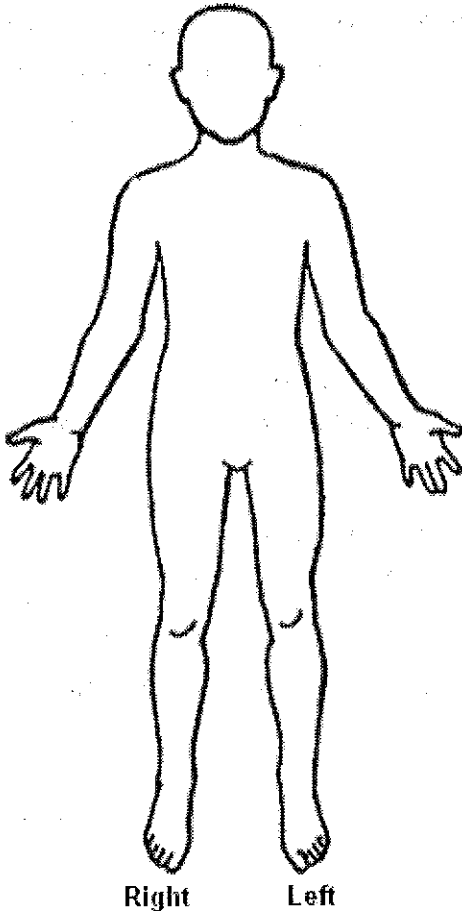
CLINICAL INFORMATION: Please check appropriate boxes

HEAD		SIDE		CHEST		SIDE	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Coughing Blood			
<input type="checkbox"/> Headaches	<input type="checkbox"/> Weakness	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Shortness of Breath			
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Numbness	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Mass	<input type="checkbox"/> Left	<input type="checkbox"/> Right	
<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Left	<input type="checkbox"/> Right				
<input type="checkbox"/> Memory Loss							
SPINE		SIDE		ABDOMEN		SIDE	
<input type="checkbox"/> Neck Lump	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Nausea / Vomiting				
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Vomiting Blood				
<input type="checkbox"/> Neck Swelling	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Blood in Stool				
<input type="checkbox"/> Arm Pain / Numbness	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Blood in Urine				
<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Jaundice				
<input type="checkbox"/> Lower Back Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Diarrhea				
<input type="checkbox"/> Leg Cramps When Walking	<input type="checkbox"/> Left	<input type="checkbox"/> Right	<input type="checkbox"/> Constipation				
			<input type="checkbox"/> Pain	<input type="checkbox"/> Left	<input type="checkbox"/> Right		
			<input type="checkbox"/> Mass	<input type="checkbox"/> Left	<input type="checkbox"/> Right		

Please answer questions on reverse side

PATIENT HISTORY AND SCREENING:

Please mark on this drawing the location of an electronic device or metal of any type inside your body.



WARNING

These items should NOT be taken into the MAGNET ROOM. Damage to the equipment, MRI Systems, and personal injury could result. DO NOT ENTER the scan room with any of these items:

- Glasses
- Removable Dental Work
- Hearing Aid
- Jewelry
- Watch
- Wallet / Money Clip
- Pens / Pencils
- Keys / Key Chains
- Coins
- Pocket Knife
- Metal Zippers / Buttons
- Belt Buckle
- Shoes
- Magnetic Strip Cards (i.e., Credit Cards, Bank Cards)
- Hairpins / Barrettes
- Metal Bra Hooks
- Bra or Girdle Under-Wire
- Safety Pins
- Hearing Aid
- OTHER ELECTRONIC DEVICES OR METAL OF ANY TYPE

The following items can interfere with the MR imaging and your safety.

Please check if you have any of these items in your body.

- | | | |
|--|--|---|
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Hearing Aids or Implants | <input type="checkbox"/> Wire Sutures |
| <input type="checkbox"/> Brain Clips | <input type="checkbox"/> Fractured Bones Treated With Metal Rods, Screws, Nails or Clips | <input type="checkbox"/> Shrapnel |
| <input type="checkbox"/> Carotid Clips | <input type="checkbox"/> Harrington Rod | <input type="checkbox"/> Dentures |
| <input type="checkbox"/> Neurostimulators (Tens-Units) | <input type="checkbox"/> Bone or Joint Pins | <input type="checkbox"/> Others (please list) |
| <input type="checkbox"/> Heart Valve | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> None of the Above (must be checked if none of the above items apply) |
| <input type="checkbox"/> Insulin Pump | <input type="checkbox"/> Metal Mesh | |
| <input type="checkbox"/> Electrodes | | |

CONSENT FORM

- I do not have electronic devices or metal of any type in, or attached to, my body.
- I certify that I have read and answered all questions.
- I will not hold any person or institution responsible for any possible omission made here.

Patient Signature

Witness