MRI REQUEST FORM ♦ JOINTS

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

G. Do you have any infections, or is your immune system weakened by sickness *(AIDS, cancer treatment)* ☐ YES ☐ NO

CLINICAL INFORMATION:

Please check appropriate boxes if you know that you have any of the following, or if the doctor is looking for any of the following.

☐Lump or Mass
☐Pain, Specify Exact Location ___________________
☐Previous Dislocation
☐Locking or Clicking Symptoms
☐Torn Ligament, Which? ____________________
☐Tendonitis
☐Cartilage Damage or Chondromalacia

☐Any Previous Surgery? Please Specify___________
☐Rupture of Muscle
☐Avascular Necrosis or Osteochondritis Dissecans
☐Baker's Cyst or Popliteal Cyst
☐Water on The Joint (Effusion)
☐Other Problems. Please Specify_______________
____

H. Have you had physical therapy, and is your pain better or worse?___________________________

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

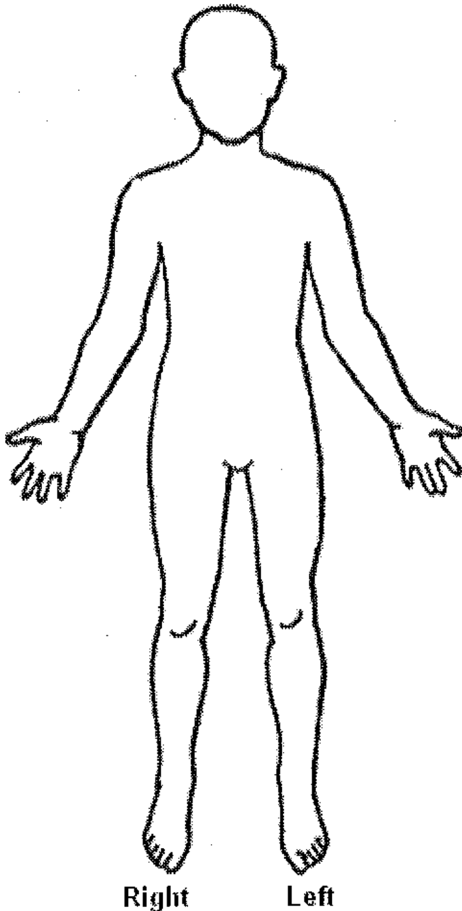
Have you had any STEROID injections? ☐ YES ☐ NO. If yes, when and where ____________________

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

Any other medication? ____

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.

☐ Cardiac Pacemaker
☐ Brain Clips
☐ Carotid Clips
☐ Neurostimulators (Tens-Units)
☐ Heart Valve
☐ Insulin Pump
☐ Electrodes

☐ Hearing Aids or Implants
☐ Fractured Bones Treated With Metal Rods, Screws, Nails or Clips
☐ Harrington Rod
☐ Bone or Joint Pins
☐ Prosthesis
☐ Metal Mesh

☐ Wire Sutures
☐ Shrapnel
☐ Dentures
☐ Others (please list)
____
☐ None of the Above (must be checked if none of the above items apply)

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