Patient Safety Screening for MRI

Ventura Orthopedics

WARNING! IF YOU HAVE A PACEMAKER, DEFIBRILLATOR OR ANEURYSM CLIP, DO NOT PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER IMMEDIATELY.

Patient Name _____ Date of Birth _____ Appt. Date _____

Please indicate if you have any of the following implants or metal inside your body:

☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Cardiac loop recorder (Insertable Cardiac Monitor)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Aneurysm clip
☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Cochlear, otologic or other ear implant
☐ Yes ☐ No Hearing aids
☐ Yes ☐ No Dentures, partial plates or dental implant
☐ Yes ☐ No Spinal cord stimulator or other neurostimulation system
☐ Yes ☐ No Surgical staples, clips, endoscopic clips or metallic sutures
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Surgically implanted device or prosthesis (penile, eye, etc.)
☐ Yes ☐ No Insulin or other drug infusion pump
☐ Yes ☐ No Breast or other tissue expander
☐ Yes ☐ No Bone growth or bone fusion stimulator
☐ Yes ☐ No Artificial or prosthetic limb

☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No Medication patches of any kind
☐ Yes ☐ No Spinal or intraventricular brain shunt
☐ Yes ☐ No Body piercings, tattoos or permanent make-up
☐ Yes ☐ No Breast feeding or pregnancy
☐ Yes ☐ No Metallic foreign body in the eye, currently or in the past, for which you previously sought medical attention
☐ Yes ☐ No Cardiac defibrillator (ICD)
☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Metallic stent, filter or coil
☐ Yes ☐ No Intraocular lens, eyelid spring or wire
☐ Yes ☐ No Cosmetic colored contact lenses
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Joint replacement (hip, knees, etc.)
☐ Yes ☐ No IUD, diaphragm or pessary
☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Breathing problem or motion disorder

IMPORTANT INSTRUCTIONS! Before entering the MRI environment or MRI system room, you must remove ALL metallic objects, including hearing aids, dentures, partial plates, keys, pagers, cell phones, eyeglasses, hairpins, barrettes, jewelry, body-piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper and tools. Failure to inform the technologist of implants or metal inside of your body may cause serious bodily injury or be life threatening. By proceeding with the MRI after discussing metal (possible or confirmed) in your body with the Ordering Physician and/or MRI Technologist, you agree to release Ventura Orthopedics Medical Group, Inc. from any and all liability for any injury. Please consult the MRI technologist if you have any questions or concerns before you enter the MRI system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MRI 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 the MRI procedure that I am about to undergo.

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

Form completed by: ☐ Patient ☐ Other _____ _____
Print Name Relationship to Patient

Form reviewed by: ☐ MRI Tech. ☐ Tech. Assist. ☐ Coordinator

Signature: _____

I have reviewed this form. All positive responses have been discussed, investigated and cleared. The patient has reviewed the form and been coached appropriately. All responses have been discussed, investigated and cleared.

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

Health History Questionnaire for MRI Examination

Patient Name _____ Appt. Date _____

Date of Birth _____ Age_____ Sex _____ Height _____ Weight _____

☐ Yes ☐ No Is your visit due to an injury?
☐ Yes ☐ No Was this a work related injury?
☐ Yes ☐ No Was it due to a motor vehicle accident?
☐ Yes ☐ No Have you filed a personal injury claim?

What is the number one symptom you are experiencing? _____

Please describe the nature and date of the injury:

_____

_____

_____

If you are experiencing pain, please mark with a "X" where the pain is located on the illustration to the right. If you are NOT currently experiencing any pain, please check the box below the illustrations.

Please list all major medical history. Be sure to include all surgeries and drug allergies.

_____

_____

_____

_____

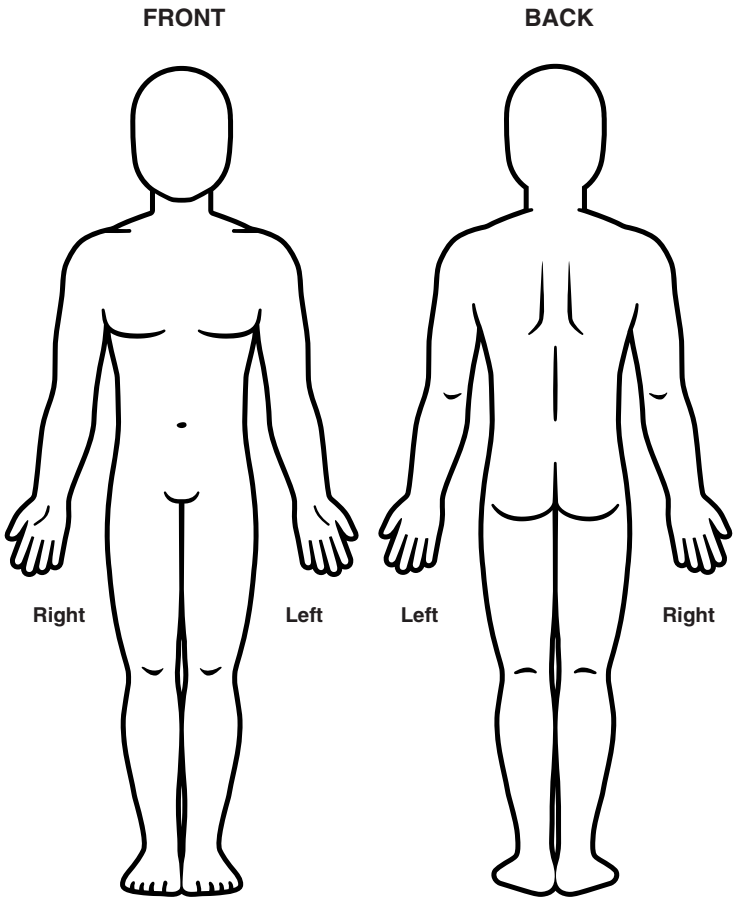
Please list any other MRIs, X-rays, CT scans or ultrasounds you may have had of the area we are taking imaging today and the date:

_____

_____

_____

_____



☐ **NOT CURRENTLY EXPERIENCING PAIN**

Technologist Notes: _____

_____

_____

_____

_____

Patient follow-up date: _____

☐ Yes ☐ No Prior surgery at scan site?
If yes, date of surgery: _____

☐ Yes ☐ No Cancer?

☐ Yes ☐ No Diabetes?

☐ Yes ☐ No Any local injection?

☐ Yes ☐ No Any physical therapy?