

**Illinois Bone and Joint Institute LLC - MRI Services : Patient Screening Form**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_ DP MG AH GV LV GU BA CHP # \_\_\_\_\_

Name (Last, First) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

MRI of the: \_\_\_\_\_ with Contrast Yes No is GFR Required Yes No

BUN/Creatinin Test done within last 30 days Yes No Ref Physician: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Phone (H) (W) (C) \_\_\_\_\_

List any Surgery (s) within the last 5 – 10 yrs. \_\_\_\_\_

Signs & Symptoms and the reason(s) for the exam: \_\_\_\_\_

Please mark if you have or have you ever had any of the following implanted in your body? (√)

- |                             |                       |                      |                              |
|-----------------------------|-----------------------|----------------------|------------------------------|
| Pacemaker/Pace wires        | Brain Aneurysm Clips  | Intra Vascular Coils | Hearing Aids                 |
| Heart valves/Stents         | Breast Markers        | Neuro Stimulators    | Surgical Clips               |
| Cataract Implants           | Breast Enhancements   | IUD                  | Stapes Prosthesis            |
| Cochlear Implants           | Power Artificial Eyes | Shunts               | Metal Plates / Pins / Screws |
| Others please specify _____ |                       |                      |                              |

- Have you had surgery within the last 8 weeks \_\_\_\_\_ Yes / No
- Have you had an MRI on the body part being scanned \_\_\_\_\_ Yes / No
- Have you had Surgery on the body part being scanned \_\_\_\_\_ Yes / No
- Do you, or have you ever worked with metal (Cut, Grind, Weld) \_\_\_\_\_ Yes / No
- Possibility of Pregnancy ( if applicable) \_\_\_\_\_ Yes / No
- Do you wear any type of Patches? Nicotine / Nitroglycerine or Pain \_\_\_\_\_ Yes / No
- Do you have a Tattoo / non removable piercing \_\_\_\_\_ Yes / No
- Do you have Dentures, Partials or dental implants \_\_\_\_\_ Yes / No
- Do you have a history of Kidney failure / Cancer \_\_\_\_\_ Yes / No
- Are you allergic to any Medication \_\_\_\_\_ Yes / No
- Are you Claustrophobic, How Severe? ( 1 – 10 ) \_\_\_\_\_ Yes / No
- Exam takes approximately 45 mins - 1hr, can you lay still \_\_\_\_\_ Yes / No

**Children under the age of 12 must always be accompanied by an adult in the waiting area**

Additional Medical Information \_\_\_\_\_

Patients Signature: \_\_\_\_\_ Schd by: \_\_\_\_\_ Schd Date: \_\_\_\_\_

Tech's Comments: \_\_\_\_\_

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