



MRI Patient Information and Screening

Premier Orthopaedics & Sports Medicine, PLC

➤ **IMPORTANT: REMOVE ALL JEWELRY BEFORE YOUR EXAMINATION – INCLUDING YOUR WATCH.** ◀

Name: _____ Date of Birth: _____

Social Security # _____ Sex: (circle) Male Female Race:(circle) Black White Other
(State of Tennessee requires this information)

Today's Date: _____ Height: _____ Weight: _____

Referring Physician: _____

List all known allergies: _____

Reason for today's MRI: _____

Have you had a previous diagnostic test for this problem? _____

If yes, what kind of test, when, and where? _____

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR INTERFERE WITH YOUR MRI. PLEASE ANSWER CAREFULLY. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please circle all answers.)

- | | | |
|-----|----|---|
| YES | NO | pacemaker / pacemaker wires |
| YES | NO | heart valve / heart surgery / stent |
| YES | NO | implanted cardiac defibrillator |
| YES | NO | brain aneurysm clip / other brain surgery |
| YES | NO | ear surgery / cochlear implant / inner ear prosthesis / hearing aid(s) |
| YES | NO | vascular access port / central venous catheter |
| YES | NO | metal slivers in eye / history of welding or metal grinding |
| YES | NO | eye surgery / ocular implants |
| YES | NO | shrapnel / bullet fragments / BBs / other metal foreign body |
| YES | NO | neurostimulator / TENS / muscle stimulator (pelvic floor, etc.) |
| YES | NO | removable dentures or partials |
| YES | NO | diaphragm / IUD |
| YES | NO | penile implant / pessary / metal mesh |
| YES | NO | IVC filter / joint replacement / metal plates, screws, clips, orthopedic implants |
| YES | NO | tattoos / piercing with metal jewelry / permanent makeup |
| YES | NO | insulin pump / pain pump |
| YES | NO | Do you have a history of cancer? If so, what type? _____ |
| YES | NO | Do you have a history of renal (kidney) disease or renal failure? |
| YES | NO | Are you undergoing renal dialysis? |
| YES | NO | Are you breastfeeding or pregnant? Date of last menstrual period: _____ |
| YES | NO | Have you had spine surgery? |

I have answered the questions above to the best of my knowledge and understand the information presented to me regarding my MRI. I am not pregnant at this time. I consent to MR examination.

Signature of the Patient / Parent / Legal Guardian: _____

Technologist Initials: _____ Contrast Type / Amount: _____