Michigan M.R.I.

Name :_____ **Date of Birth:** _____**Chart #**_____

Ordering Physician: _____**Telephone:**_____**Fax:**_____

MRI Scan:_____ **Notes:** _____

Do you have or have you ever had any of the following?

☐ **Yes** ☐ **No** Implanted Cardiac Pacemaker/Defibrillator
☐ **Yes** ☐ **No** Heart Surgery/ Valves/Stents/Shunts/Filters/Coils
☐ **Yes** ☐ **No** Eye Surgery/Implants/Spring/Wires/Retinal Tack
☐ **Yes** ☐ **No** Injury to the Eye Involving Metal or Metal Shavings
☐ **Yes** ☐ **No** Mesh Implants/Wire Sutures or staples/Clips/Internal Electrodes
☐ **Yes** ☐ **No** Implanted Drug Infusion Pumps/Ports/Catheters
☐ **Yes** ☐ **No** Using any medication in the form of a topical patch
☐ **Yes** ☐ **No** Tattoo's/Permanent Make-up/Body Piercing/Patches
☐ **Yes** ☐ **No** Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig

☐ **Yes** ☐ **No** Claustrophobia
☐ **Yes** ☐ **No** Dentures/Partials/Dental Implants
☐ **Yes** ☐ **No** Gunshot Wounds/Shrapnel/BB
☐ **Yes** ☐ **No** Brain Aneurysm Clips/ Brain Surgery
☐ **Yes** ☐ **No** Previous MRI for this area of the body?
☐ **Yes** ☐ **No** Ear Surgery/Cochlear Implants/Hearing Aids
☐ **Yes** ☐ **No** Orthopedic pins/Screws/Rods/Joints/Prosthesis

List any Drug Allergies: _____

Previous Treatments (if any) please provide a brief description if applicable. **(Physical Therapy, Chiropractic, Injections, etc):**

_____

1. **What is your main complaint?** _____ **For How Long?** _____
2. **Describe your pain, (i.e. sharp, burning, dull, etc.).** _____
3. **Does anything make the pain worse? If so, what?** _____
4. **Do you have numbness?** _____**Weakness?** _____**If so Please Explain**_____
5. **Have you had any injury/trauma to this area?**_____ **Explain.** _____
6. **What type of surgery, if any, was done on this area of your body? When?** _____
7. **Have you ever been diagnosed with cancer?** _____ **When?** _____
   What Kind and Where in body? _____
8. **Have you had radiation/chemotherapy?** _____
9. **Any problems with dizziness or being off-balance?** _____**Explain** _____
10. **Please list any medical conditions that you have:**_____

MRI Contrast History: **(Please circle Yes or No)**

Have you ever had MRI contrast?	**Yes / No**	**Any history of Hypertension?**	**Yes / No**
Did you have any kind of reaction?	**Yes / No**	**Any history of Diabetes?**	**Yes / No**
Are you pregnant at this time?	**Yes / No**	**History of Severe Kidney or Liver Disease?**	**Yes / No**
Are you breast feeding at this time?	**Yes / No**	**Pending Kidney or Liver Transplant?**	**Yes / No**

Sometimes MRIs requires an injection of contrast. MRI contrast (Gadolinium) is non-iodine based and is administered through an intravenous injection. During administration, you may experience a sensation of contrast material being injected, which is normal and expected. MRI Contrast is quite safe, however, as with all medications there is a slight risk of an allergic reaction. The physician and staff in the MRI Department are trained to respond to any emergency situation that may develop.

I attest that the above information is correct to the best of my knowledge. I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

X_____ _____ _____
Patient/Parent/Legal Guardian **MRI Technologist's Signature** **Date**

_____ _____ _____
Amount & Type of Contrast **Lot Number** **Expiration Date**