

EAST RIVER MEDICAL IMAGING
MAGNETIC RESONANCE IMAGING

Patient Name: _____ Acct No: _____ Exam Date: _____
Age: _____ Sex: _____ Height: _____ Weight: _____
Type of Exam: _____ Referring Physician: _____

*** IMPORTANT: Please notify the receptionist if you answer "YES" to any of the questions below. The receptionist will inform the technologist/radiologist of your responses. ***

YES	NO	PLEASE CHECK
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been a machinist, welder, or metal worker?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had metal removed from your eyes?
<input type="checkbox"/>	<input type="checkbox"/>	Have you been shot with bullets, BBs, or shrapnel?
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	Any surgery on area to be imaged? _____
		If yes, when? _____

YES	NO	DO YOU HAVE ANY OF THE FOLLOWING IN OR ON YOUR BODY?
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker, pacer wires or defibrillator
<input type="checkbox"/>	<input type="checkbox"/>	Brain/Aneurysm clips
<input type="checkbox"/>	<input type="checkbox"/>	Ear Implants or Hearing Aids
<input type="checkbox"/>	<input type="checkbox"/>	Electrical Stimulators
<input type="checkbox"/>	<input type="checkbox"/>	Implant/Prosthesis
<input type="checkbox"/>	<input type="checkbox"/>	Infusion Pumps
<input type="checkbox"/>	<input type="checkbox"/>	Coils, catheters, filters or wires in blood vessels
<input type="checkbox"/>	<input type="checkbox"/>	Artificial limbs or joint replacement
<input type="checkbox"/>	<input type="checkbox"/>	Tattooed Eyeliner
<input type="checkbox"/>	<input type="checkbox"/>	Artificial heart valves
<input type="checkbox"/>	<input type="checkbox"/>	Magnetic dental implants
<input type="checkbox"/>	<input type="checkbox"/>	Transdermal patches
<input type="checkbox"/>	<input type="checkbox"/>	IUD
<input type="checkbox"/>	<input type="checkbox"/>	Tissue expander for future implants

*** WARNING: Before entering the MR room, you must remove all metallic objects including HEARING AIDS, DENTURES, CREDIT/BANK CARDS, watch, keys, cell phone, beeper, hair pins, barrettes, body piercing jewelry, money clips, magnetic strip cards, pens, pocket knife, and nail clipper. Please consult the technologist if you have any questions or concerns BEFORE you enter the MR room. ***

Signature _____ Date: _____
Print Name: _____

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TECHNOLOGIST'S USE ONLY

Patient Complaint/Diagnosis _____

Any previous imaging studies in this area? Yes No
If yes, where _____ Date of Study _____
Technologist _____