**Patient Name:** _____
**DOB:** _____ **Age:** ___ **yrs** **Gender:**
**Location:** Community MRI Services NOR
**Exam Date / Exam Time:** _____
**Exam Reason:** _____
**Patient Number:** _____

**Ordering Physician:** _____

**HEIGHT:** _____ **WEIGHT:** _____

**PLEASE CHECK ALL THE OPTIONS IN THIS SECTION WHICH APPLY OR MAY APPLY TO THE PATIENT**

*Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the* ***MRI CANNOT BE DONE:***

| | Yes | No |
|---|---|---|
| 1. Implanted insulin or medication pump | ☐ | ☐ |
| 2. Implanted neuro-stimulator (tens) | ☐ | ☐ |
| 3. Do you currently have a pacemaker | ☐ | ☐ |
| 4. Have you had a pacemaker removed | ☐ | ☐ |
| 5. Defibrillator | ☐ | ☐ |
| 6. Magnetic dental implants | ☐ | ☐ |
| 7. Magnetic artificial eye | ☐ | ☐ |

*Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI CAN BE DONE:*

| | Yes | No |
|---|---|---|
| 1. Previous spine surgery | ☐ | ☐ |
| 2. Heart bypass surgery (6 weeks post) | ☐ | ☐ |
| 3. Cataract surgery (6 weeks post) | ☐ | ☐ |
| 4. Gallbladder surgery (6 weeks post) | ☐ | ☐ |
| 5. Joint replacement/orthopedic hardware | ☐ | ☐ |
| 6. Body piercing | ☐ | ☐ |
| 7. Dentures | ☐ | ☐ |
| 8. Hearing aids | ☐ | ☐ |
| 9. Latex allergies / risk for latex allergies | ☐ | ☐ |
| 10. Claustrophobic | ☐ | ☐ |
| 11. Transdermal patch medication and/or nicotine | ☐ | ☐ |
| 12. Itching, hives, running nose, eye irritation, wheezing after contact with rubber products? *Examples: rubber gloves, balloons, diaphragms or condoms* | ☐ | ☐ |

*Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI* ***MAY NEED TO BE*** *discussed with the Radiologist first: (Manufacturer, model and make of any implanted devices must be known)*

| | Yes | No |
|---|---|---|
| 1. Brain surgery | ☐ | ☐ |
| 2. Brain aneurysm clips | ☐ | ☐ |
| 3. Inner ear implant | ☐ | ☐ |
| 4. Pregnant or may be pregnant? | ☐ | ☐ |
| 5. Nursing? | ☐ | ☐ |
| 6. Retina repair clips | ☐ | ☐ |
| 7. Heart valve | ☐ | ☐ |
| 8. Implanted shunts or ports | ☐ | ☐ |
| 9. Penile implants | ☐ | ☐ |
| 10. Shrapnel or other metal particles | ☐ | ☐ |
| 11. Metal grinding/welding without eye protection | ☐ | ☐ |
| 12. Tattooed eyeliner | ☐ | ☐ |
| 13. Previous reaction to (MRI) contrast | ☐ | ☐ |
| 14. Kidney disease, single kidney | ☐ | ☐ |
| 15. Currently on dialysis | ☐ | ☐ |
| 16. Multiple myeloma | ☐ | ☐ |
| 17. Medication for high blood pressure | ☐ | ☐ |
| 18. Diabetic | ☐ | ☐ |
| 19. Surgical dressing containing silver | ☐ | ☐ |

_____
*Patient Signature* *Date*

_____
*Technologist Signature* *Date*