



MRI PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Date: ____/____/____ Weight: _____

Exam Ordered: _____ Referring Physician: _____

Are you Claustrophobic? Yes No Medication Prescribed: _____

Clinical History/Symptoms: _____

The following items may interfere with MRI and some can be potentially hazardous. Do you have any of the following? If yes, please explain.

- Y N Brain surgery/Aneurysm clips
- Y N Cardiac pacemaker
- Y N Heart surgery/Heart valve
- Y N Shunts/Stents/Intravascular coil
- Y N Eye surgery/Implants
- Y N Injury to eyes involving metal at anytime
- Y N Penile prosthesis
- Y N Orthopedic pins, screws, rods, plates, etc.
- Y N Neurostimulator/Bio stimulator/TENS-Unit
- Y N History of cancer or tumors; Type/When:
- Y N Radiation therapy/Chemo therapy
- Y N Tattooed eyeliner
- Y N Ear surgery/Cochlear implants/Hearing aids
- Y N Vascular access port
- Y N Diaphragm/IUD/Pessary
- Y N Metal mesh implants/Wire sutures/Wire staples/Internal electrodes
- Y N Electrical, mechanical or magnetic implants; Type:
- Y N Implanted drug infusion pump/Insulin pump
- Y N Implanted cardiac defibrillator
- Y N Pacing wires, Swan-Ganz Catheter
- Y N Do you know/suspect that you're pregnant?
- Y N Shrapnel/Bullets
- Y N Body piercing
- Y N Dentures/Braces/Partial plate
- Y N Sickle-cell anemia?
- Y N Have you had surgery in the past six weeks? Type:
- Y N Have you had prior diagnostic studies to this area? Type:

I attest that the above information is correct to the best of my knowledge.

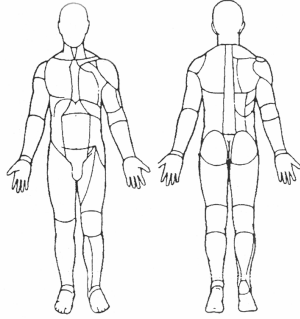
MRI Patient signature: _____

Date: ____/____/____

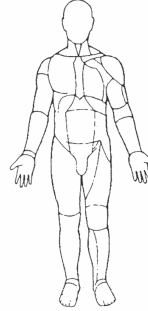
Technologist signature: _____

Date: ____/____/____

Draw on the figures below where the pain or symptoms are located:



Please draw on the figure below the location of any metal in your (or the minor's) body:



CONSENT FOR MRI SCAN & CONTRAST AGENT

Your physician has referred you for an MRI examination which may require an injection of a contrast agent into your bloodstream. The injection of contrast may provide additional diagnostic information and improve your exam. The vast majority of patients have no side effects whatsoever from this injection. Occasionally, mild, short-lasting side effects such as headache or nausea may occur. More severe side effects are extremely rare.

A typical MRI exam is painless and could last up to one hour. The technologist will assist you into the correct position on the MRI table and help make you comfortable during the procedure. It is extremely important to lie very still during the exam as motion can obstruct image quality. You will hear a knocking sound when the scanner is acquiring images. The technologist will provide you with earplugs to reduce the noise.

I give consent to the performance of the MRI scan(s) including the injection of contrast material if indicated.

Patient signature (Parent or guardian must sign for minors)

Date

FINANCIAL AGREEMENT

I understand that I will receive a bill from Pinnacle Imaging Center and separate billings from each physician who performs services and I agree to pay these services. I also agree to pay a return check service charge of \$25.00, finance charges, attorney fees, cost of collections, and any other charges assessed pursuant to Pinnacle Imaging Center billing policies.

I hereby assign, transfer and set over to Pinnacle Imaging Center sufficient moneys and/or benefits to which I may be entitled from governmental agencies, insurance carriers or others who are financially liable from my medical care to cover the costs of the treatment rendered to me or my dependent at Pinnacle Imaging Center.

Patient signature (Parent or guardian must sign for minors)

Date