CONE HEALTH
The Network for Exceptional Care

MRI
UPPER EXTREMITY PATIENT HISTORY AND SCREENING

Name: _____ Referring Physician: _____

Please explain your present complaint or problem in detail: _____

_____

How long have you had this problem? _____

Any previous injury or surgery to this area? ☐ No ☐ Yes When? _____

If yes, please explain what was done: _____

_____

Please check if you have any of the following:

☐ Lump or mass	☐ Weakness	☐ Fever
☐ Dislocation	☐ Steroid Therapy	☐ Cancer to this area
☐ Numbness	☐ Radiation Therapy	

If you checked anything listed above, please explain: _____

_____

Does anything make the pain/condition worse? ☐ No ☐ Yes, Explain: _____

_____

Does anything make the pain/condition better? ☐ No ☐ Yes, Explain: _____

_____

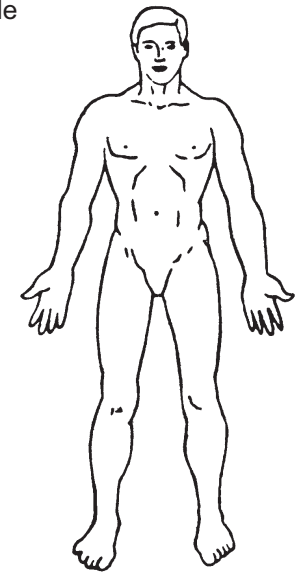
Have you had any previous exams of the body part being scanned today? ☐ No ☐ Yes

If yes , what type of exam? _____

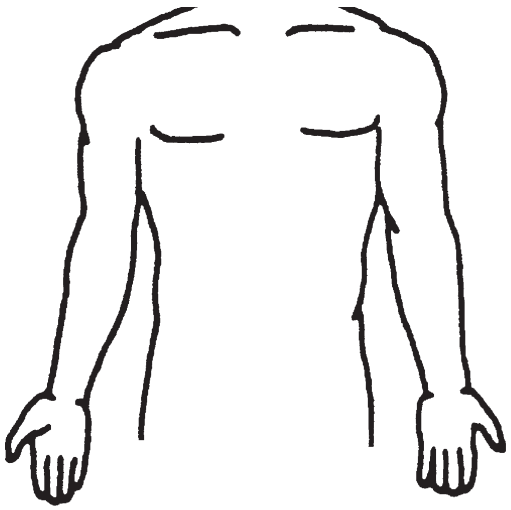
When and where? _____

Please circle the area where you are having problems on the pictures below:

Right Side Left Side



Right Arm Left Arm



(please turn over)

PATIENT MRI SAFETY SCREENING FORM

Name:_____ Weight:_____

Date of Birth:_____ Last menstrual period:_____ N/A☐

Please check any that apply:
Possibly pregnant? ☐ Yes Claustrophobic (afraid of closed in areas)? ☐ Yes
Have you **EVER** worked around metal grinding/filing or welding? ☐ Yes
Have you **EVER** had metal particles in your eyes? ☐ Yes

Please list any surgeries you have had : _____
_____

Please list any known allergies to latex, tape or drugs that you have:
_____

Please list current medications _____
_____
_____

Do you have history of renal disease or dialysis? ☐ No ☐ Yes
Do you have history of High Blood Pressure? ☐ No ☐ Yes
Do you have history of diabetes? ☐ No ☐ Yes
Do you have Sickle Cell? ☐ No ☐ Yes
Do you have history of liver disease? ☐ No ☐ Yes
Do you have history of asthma? ☐ No ☐ Yes

The following items ***can*** interfere with MR imaging and ***can*** be hazardous to your safety. Please check appropriate items & notify the Technologist if you have any of the following:

_____Cardiac pacemaker	_____Hearing aids	_____Brain clips
_____Cochlear implants	_____Aortic clips	_____Shunts
_____Carotid clips	_____Joint replacements	_____ Neurostimulators (Tens)
_____Harrington rod	_____Heart valve replacements	_____Bone or joint pins
_____Insulin pump	_____Prosthesis	_____Electrodes
_____Wire sutures	_____Metal mesh	_____Shrapnel
_____Metal plates	_____Dental/teeth work with magnets	
_____Medication patch	_____Therapeutic Magnets or screws, nails or metal rods	

_____Other (please list) _____

DO NOT ENTER THE SCANNING ROOM WITH ANY OF THE FOLLOWING ITEMS:
Hearing aids, Magnetic strip cards (credit cards, bank cards), Jewelry, Hairpins/barrettes, Glasses, Watch, Wallet/Money Clip, Pocket knife, Safety pins, Pens/pencils, Phone/pager, Keys, Coins

**** Lockers will be provided to lock patient valuables ****

I have reviewed and confirmed that the above information is complete to the best of my knowledge:

Pt. Signature:_____ **Date:**_____

Please turn form over for additional information*****

MRI Technologist has interviewed patient: _____Tech
IV angiocath started: _____ RN/Tech
IV angiocath has been D/C: _____RN/Tech