CONE HEALTH®
The Network for Exceptional Care

# MRI

## LOWER EXTREMITY PATIENT HISTORY AND SCREENING

Name: _____ Referring Physician: _____

Please explain your present complaint or problem in detail: _____

_____

Is this problem a result of an injury? ☐ No ☐ Yes

If so, how did it occur? _____

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

☐ Numbness ☐ Radiation Therapy

If you checked anything listed above, please explain: _____

_____

Do you have a personal history of cancer? ☐ No ☐ Yes If so, please list what kind? _____

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

_____

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

_____

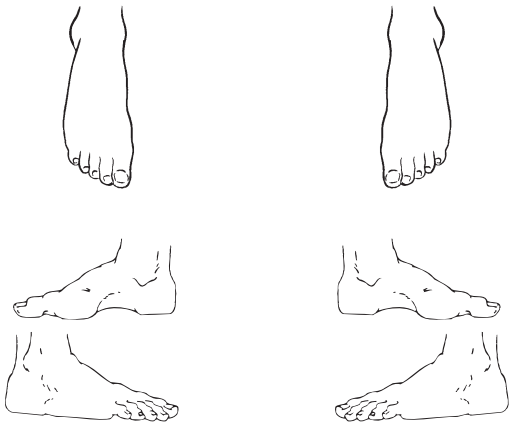
Have you had any previous exams of the body part being scanned today? ☐ No ☐ Yes

If yes, what type of exam? _____

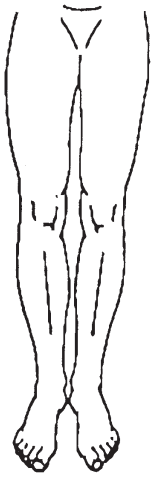
When and where? _____

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

Right Foot Left Foot



Right Left



(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 knkowledge:

**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