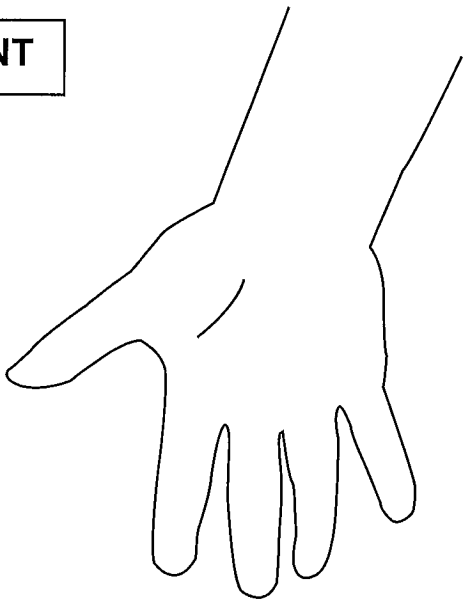


Patient: _____ Age: _____ Sex: _____ Exam Date: _____

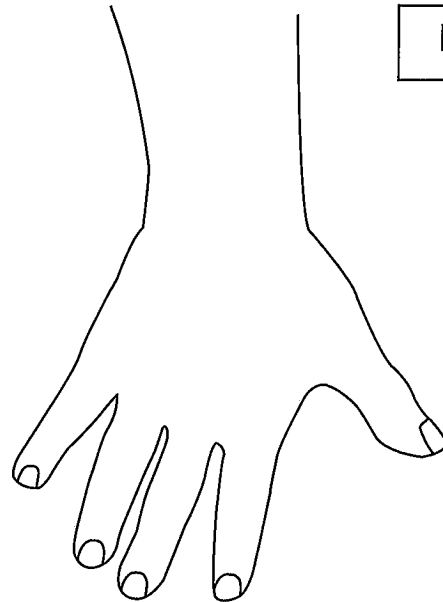
Referred by: _____ Weight: _____

Please shade area where you have had pain or other symptoms including numbness or tingling

FRONT



BACK



RIGHT

LEFT

1. Do you have pain, popping, numbness, or tingling?
2. Do you have trouble picking up objects?
3. Do you have loss of grip strength?
4. Do you unexpectedly drop objects?
5. Is this a result of an accident? If yes, date _____
 Explain:
6. Is this a result of a sport injury?
 If yes, please explain:
7. Have you had surgery on the area being scanned?
 If so when?

Yes/No
 Yes/No
 Yes/No
 Yes/No
 Yes/No

Yes/No
 Yes/No
 Yes/No
 Yes/No
 Yes/No

Yes/No
 Yes/No

Yes/No
 Yes/No

Patient Signature: _____ **Date:** _____

**MAGNETIC RESONANCE IMAGING
 PATIENT SAFETY SCREENING HISTORY**

Patient Name: _____

Date: _____ Date of Birth _____

Exam _____

The following items may interfere with MR Imaging and some may be hazardous to your safety. Please circle if you have or have had any of the following (if yes, please explain):

- | | | | |
|--|-----|----|-------|
| A heart/cardiac pacemaker | Yes | No | _____ |
| Any type of implanted electrode or wire | Yes | No | _____ |
| Heart bypass surgery | Yes | No | _____ |
| Insertion of heart valve | Yes | No | _____ |
| Brain/aneurysm clips | Yes | No | _____ |
| Aortic or other blood vessel clips | Yes | No | _____ |
| Insertion of a neurostimulator (Tens Unit) | Yes | No | _____ |
| Insertion of an insulin or drug pump | Yes | No | _____ |
| Hearing aid or surgery for hearing loss | Yes | No | _____ |
| Insertion of any "shunt" or "stent" device | Yes | No | _____ |
| Metal plates, pins, screws, nails or rods | Yes | No | _____ |
| Insertion of metal implants or prosthesis | Yes | No | _____ |
| Partial plate or dentures | Yes | No | _____ |
| Shrapnel or bullet wounds | Yes | No | _____ |
| Work with metal (welding/grinding) | Yes | No | _____ |
| Metal in or removed from your eyes | Yes | No | _____ |
| Any known allergies | Yes | No | _____ |
| Pregnant, possibly pregnant, or nursing | Yes | No | _____ |
| Breast implants or IUD | Yes | No | _____ |
| Nitroglycerine patches | Yes | No | _____ |
| Piercings, Tattoos | Yes | No | _____ |
| Permanent Make-up | Yes | No | _____ |
| Are you claustrophobic? | Yes | No | _____ |

Please list the following:

Previous surgery _____

Previous diagnostic studies on area being scanned _____

Notes: Anyone entering the scan room should remove all metal or magnetic objects, including watches, keys, hearing aids, credit cards, pagers, hair pins, jewelry, safety pins, coins, eyeglasses, pens, tools and etc.

MRIs performed at New West are reviewed by a radiologist to ensure an accurate diagnosis. You will receive a separate bill from the radiologist for this service.

The above information is accurate to the best of my knowledge.

 Patient Signature

 Date

 Parent/Guardian Signature

 Date

 Technologist's Signature

 Date

Arthrogram
 Contrast _____ Amount _____ Site _____ Time _____ Injector's initials _____