

MRI CLINICAL INFORMATION

Date of Scan: _____ Time: _____

Last Name: _____ First Name: _____ Age: _____

Date of Birth: _____ Referring Doctor: _____ Height: _____ Weight: _____

Home Telephone: _____ Work Telephone: _____

Exam/HX & Clinical DX: _____

Insurance Company: _____

DO YOU HAVE A WRITTEN SCRIPT FROM YOUR DOCTOR? _____

1. WHO IS SCHEDULING PATIENT? _____

DO YOU HAVE ANY BRAIN ANEURYSM CLIPS? _____

- a. ____ Have you had any surgical procedures to the area being scanned? If so please give details _____
- b. ____ Do you have a history of cancer?
- c. ____ Carotid clips
- d. ____ Neurostimulator
- e. ____ Cardiac pacemaker
- f. ____ Heart valve
- g. ____ Inner ear implant
- h. ____ Claustrophobia
- i. ____ Are you or have you ever been a metal worker?
- j. ____ Do you have any metal implants?
- k. ____ Are you pregnant or breast feeding?
- l. ____ Have you ever had an injury or surgery to the eye involving a metal object?
- m. ____ Any type of intravascular stent or shunt?
- n. ____ Sickle cell anemia?

CT/MRI _____ Ultrasound _____

Nuclear Medicine _____ X-ray _____