



MAGNETIC RESONANCE IMAGING (MRI) PROCEDURE SCREENING FOR PATIENTS

Please read the following questions carefully

- | | | |
|--|-----|----|
| 1. Have you experienced or had and problems related to previous MRI examination or procedure?
If yes, please describe: _____ | Yes | No |
| 2. Have you had an injury to the eye involving a metallic object or fragment?(metallic slivers, shavings, etc.)
If yes, please describe: _____ | Yes | No |
| 3. Have you ever been injured by a metallic object or foreign body (BB, bullet, shrapnel, etc.)
If yes, please describe: _____ | Yes | No |
| 4. Are you currently taking or have you recently taken any medication or drug?
If yes, please describe: _____ | Yes | No |
| 5. Are you allergic to any medication?
If yes, please list: _____ | Yes | No |
| 6. Do you have a history of asthma, allergic reaction, respiratory disease or any other reaction to a contrast medium or dye used for an MRI, CT or X-Ray examination?
If yes, please describe: _____ | Yes | No |
| 7. Do you have anemia or any disease that affects your blood or a history of renal (kidney) disease or seizures? | Yes | No |

FOR FEMALE PATIENTS ONLY

- | | | | |
|--|------------------|-----|----|
| 1. Date of last menstrual cycle: _____ | Post menopausal? | Yes | No |
| 2. Are you pregnant or experiencing a late menstrual cycle? | | Yes | No |
| 3. Are you taking any type of fertility medication or having fertility treatments? | | Yes | No |
| 4. Are you currently breastfeeding? | | Yes | No |



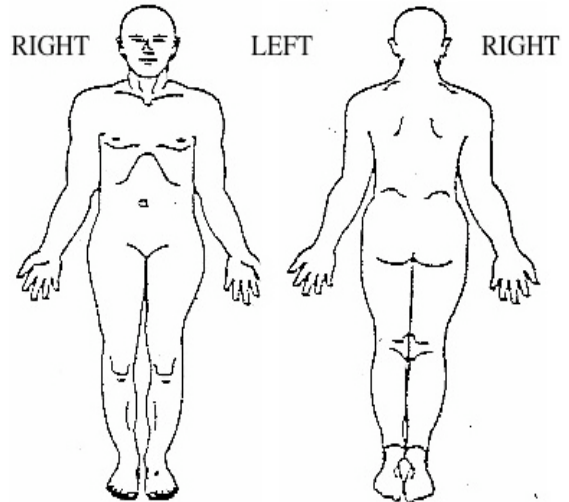
WARNING

Certain implants, devices, or objects may be hazardous to you and/ or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MRI system room or MR environment if you have any question or concern regarding implant device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following

- | | | |
|-----|----|--|
| Yes | No | Aneurysm Clip(s) |
| Yes | No | Cardiac pacemaker |
| Yes | No | Implanted cardioverter defibrillator (ICD) |
| Yes | No | Electronic implant or device |
| Yes | No | Magnetically-activated implant or device |
| Yes | No | Neurostimulation system |
| Yes | No | Spinal chord stimulator |
| Yes | No | Internal electrodes or wires |
| Yes | No | Bone growth/bone fusion stimulator |
| Yes | No | Cochlear, otologic, or other ear implant |
| Yes | No | Insulin or other infusion pump |
| Yes | No | Implanted drug or fusion device |
| Yes | No | Any type pf prosthesis (eye, penile, ect) |
| Yes | No | Heart valve prosthesis |
| Yes | No | Eyelid spring or wire |
| Yes | No | Artificial or prosthetic limb |
| Yes | No | Metallic stent, filter, or coil |
| Yes | No | Shunt (spinal or introvenricular) |
| Yes | No | Vascular access port and/ or catheter |
| Yes | No | Radiation seeds or implants |
| Yes | No | Swan-Ganz or thermo dilution |
| Yes | No | Medication patch |
| Yes | No | Any metallic fragment or foreign body |
| Yes | No | Wire mesh implant |
| Yes | No | Tissue expander (e.g., breast) |
| Yes | No | Surgical staples, clips, or metallic sutures |
| Yes | No | Joint replacement (hip, knee, ect.) |
| Yes | No | Bone/joint pin, screw, nail, wire, plate, ect. |
| Yes | No | IUD, diaphragm, or pessary |
| Yes | No | Dentures or partial plates |
| Yes | No | Tattoo or permanent makeup |
| Yes | No | Body piercing jewelry |
| Yes | No | Hearing aid (Remove before entering MR system |
| Yes | No | Other implant _____ |

Please mark on the Figure(s) below the location of any implant or metal inside of or on your body



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads. Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE you enter the MR system room.**

NOTE: you may be advised to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____

Date: _____



Patient Name: _____ Date: _____

Feel free to ask any questions you may have at the time of your exam.

Try to be specific and use as many dates as you can.

Date Symptoms started or Date of incident:

Symptoms &/or Change in symptoms:

Recent Treatments/Medications used? Are they relieving your symptoms?

Past Injuries to Area:

Do You Have a History of Cancer?

Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? Yes No

If yes, please indicate the date and type of surgery:

Date: _____ Type of Surgery: _____
Mo. Day Yr.

Date: _____ Type of Surgery: _____
Mo. Day Yr.

Do you have a follow up appointment scheduled with your doctor?

Yes No

If yes, Date: _____ Time: _____



Patient Signature Form

Verification of Document Receipt
Privacy Notice and
Patients Rights and Responsibilities

I have been given the opportunity to read a copy of the "Privacy Notice" and "Patient Rights and Responsibilities." I understand that if I have any questions regarding these documents I may call NORTH STAR DIAGNOSTIC IMAGING at 214-618-3420 or 972-954-8001 for additional explanation.

Signature of Patient or Guardian: _____ **Date:** _____

Assignment of Insurance Benefits and Release of Information for Billing Purposes

I, the undersigned, have insurance coverage with _____ and assign directly to NORTH STAR DIAGNOSTIC IMAGING, SOUTHWEST IMAGING AND INTERVENTIONAL SPECIALIST AND/OR NORTH TEXAS RADIOLOGY all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient or Guardian: _____ **Date:** _____

Patient Request of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted at the following number: _____

Please circle all that apply:

OK to leave message with detailed information

Leave message with call-back number only

Signature: _____ **Date:** _____

NORTH STAR STAFF SIGNATURE: _____ **Date:** _____