MRI
History & Screening

OrthoVirginia

_____
Date of scan

Name _____ MRN _____

DOB _____ Age _____ Weight _____ Ordering Doctor _____

Reason for the MRI (symptoms)_____

The following item can interfere with images and some may be hazardous to your safety. Please indicate if you have any of the following:

	Yes	No		Yes	No
Pacemaker or defibrillator			Body piercings (Removable & Non-Removable)		
Heart valve replacement			Body Modification Implants– dermal studs		
Neurostimulators (Tens Units)			Tattoos done before 1975		
Internal electrodes or wires			permanent eye liner		
Brain Surgery of any kind			Cochlear ear implant or Hearing aids		
Aneurysm surgery			Greenfield, or vena cava filter		
Ear or eye surgery			Implanted medication pumps		
Spinal or ventricular Shunt			Medication patch		
Vascular port access			Cancer, chemotherapy, or radiation therapy		
Joint replacement			Breast implant / tissue expander		
Metal plates, pins, screws, wires			Pregnant or breast feeding		
Wounded by bullets or shrapnel			Blood disorder i.e. Anemia or Diabetes		
IUD or diaphragm			Respiratory problems		
Penile prosthesis			Seizures or epilepsy		
Pessary			Claustrophobia—fear of small spaces		

Please list any surgeries you have had: _____

_____

_____

Have you in your lifetime, worked around metal, or performed metal grinding, or welding, including auto body work? _____ Have you ever gotten metal in your eyes? _____
Do you have stents of any kind? _____
Are you allergic to Latex? _____
Have you ever had an MRI scan before? _____

Please remove any of the following items prior to your exam:

glasses, hearing aids, removable dental work, watch/jewelry, wallet, credit cards, keys, wigs/hairpiece, hairpins/clips, safety pins, and bra.

I hereby certify the above information is correct to the best of my knowledge:

Patient: _____ **Date:** _____

Technologist: _____ **Date:** _____