family foot docs

MRI SCREENING FORM

Last Name---First-------------------------------------MI---------------------------

Date of Birth--Sex: M F (circle one)   weight-------height--------------------------------------

Address--City----------------------------State------- Zip----------------------------------

Home Phone (   ) ------------------------------------- Work----------------------------------Mobile---

Ordering Physician---

Date of MRI Scan---

Examination Performed---

Please indicate if you have any of the following: **Circle Yes or No**

Cardiac Pacemaker / Cardiac Valve Replacement	**yes**	**no**
Brain Aneurysm Clip / Shunt	**yes**	**no**
Aortic Clip / Surgical Clips	**yes**	**no**
Implanted Neurotransmitter (electronic device)	**yes**	**no**
Insulin Pump / Infusion device (internal / external)	**yes**	**no**
Hearing Aids (remove)	**yes**	**no**
Cochlear implant / other internal hearing aid	**yes**	**no**
Prosthetic device	**yes**	**no**
Joint replacements, metal rods, plates, screws, nails	**yes**	**no**
(post op six weeks)	**yes**	**no**
Shrapnel, bullet or other foreign body	**yes**	**no**
Are you pregnant or trying to get pregnant?	**yes**	**no**
Have you had an eye injury involving metal or do you work	**yes**	**no**
with metal occupationally?		
Tattoos, body piercings	**yes**	**no**
Known Allergies list:	**yes**	**no**

Have you had any surgeries of the Heart, Brain, Spine or Abdomen? If yes, what was done and when?

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____.

Had you had a MRI before of this same body part? If yes, at what facility and when was it performed?
____.

I have read and understand all of the above compatibility questions?

____
Signature of patient or guardian   Date

____
Signature of person conducting screening   Date