iCare Diagnostic Imaging, LLC
2781 Freeway Blvd, Suite 160
Brooklyn Center, MN 55430

MRI PATIENT SCREENING FORM

PERMANENT RECORD – NOT FOR BILLING

PATIENT & APPOINTMENT INFORMATION

NAME: _____ DATE OF SERVICE: _____

DOB: _____ SCHEDULE TIME: _____

PHYSICIAN: _____ EXAM TYPE: _____

PATIENT & INJURY INFORMATION

HEIGHT: _____ WEIGHT: _____

IS TODAY'S VISIT DUE TO AN INJURY? Yes No IF YES, DATE OF INJURY: _____

SPORTS INJURY? Yes No MOTOR VEHICLE? Yes No WORK INJURY? Yes No

WORKERS COMP CLAIM #: _____

DESCRIBE YOUR SYMPTOMS: _____

_____

HAVE YOU HAD A PREVIOUS MRI, CT or X-RAY RELATED TO THIS VISIT? Yes No

IF YES, WHEN and WHERE? _____

PLEASE CHECK ALL THE OPTIONS IN THIS SECTION WHICH APPLY OR MAY APPLY TO THE PATIENT

Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI CANNOT BE DONE:

	Yes	No
1. Implanted insulin or medication pump		
2. Implanted neuro-stimulator (tens)		
3. Pacemaker		
4. Defibrillator		
5. Magnetic dental implants		
6. Magnetic artificial eye		

Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI CAN BE DONE:

	Yes	No
1. Previous spine surgery		
2. Heart bypass surgery (6 weeks post)		
3. Cataract surgery (6 weeks post)		
4. Gallbladder surgery (6 weeks post)		
5. Joint replacement/orthopedic hardware		
6. Body piercing		
7. Dentures		
8. Hearing aids		
9. Latex allergies / risk for latex allergies		
10. Claustrophobic		
11. Transdermal patch medication and/or nicotine		
12. Itching, hives, running nose, eye irritation, wheezing after contact with rubber products? *Examples: rubber gloves, balloons, diaphragms or condoms*		

Please indicate whether each of the following applies to the patient. If the answer is yes to any of the following the MRI MAY NEED TO BE discussed with the Radiologist first: *(Manufacturer, model and make of any implanted devices must be known)*

	Yes	No
1. Brain surgery		
2. Brain aneurysm clips		
3. Inner ear implant		
4. Pregnant or may be pregnant?		
5. Breast feeding		
6. Retina repair clips		
7. Heart valve		
8. Implanted shunts or ports		
9. Penile implants		
10. Shrapnel or other metal particles		
11. Metal grinding/welding without eye protection		
12. Tattooed eyeliner		
13. Previous reaction to (MRI) contrast		
14. Kidney disease		
15. Currently on dialysis		
16. Diabetic		
17. Surgical dressing/bandage		

_____

Patient Signature *Date*

_____

Technologist Signature *Date*