CLARKSVILLE IMAGING CENTER
OPEN MRI • CT • ULTRASOUND

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MAGNETIC RESONANCE IMAGING
PATIENT INFORMATION FORM

Name: _____ Exam Ordered: _____

Birth Date: _____ Reason for Exam: _____

Physician: _____ Weight: _____

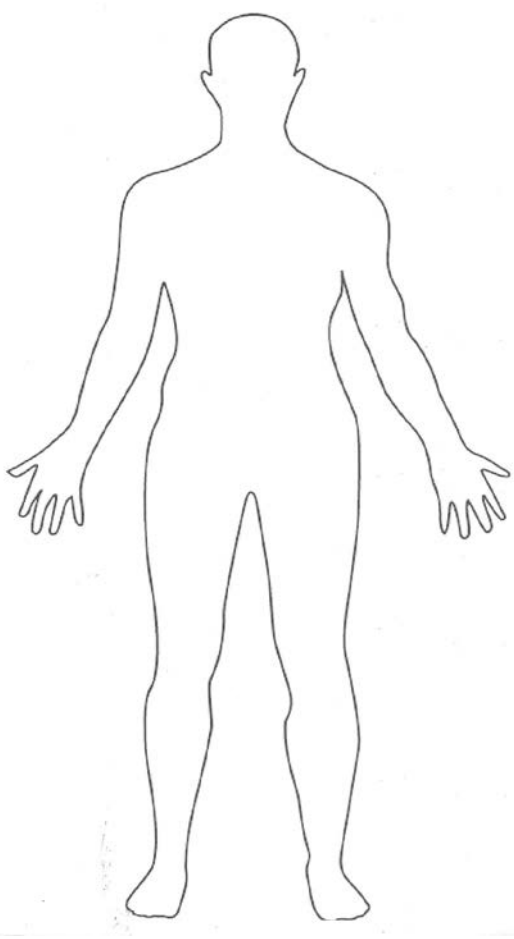
Previous *MRI* or *CT*: _____ Date: _____ Facility where study performed: _____

PATIENT SCREENING & HISTORY

You will be required to lock all valuables and remove all metal objects located on your body prior to entering the MRI room. Clarksville Imaging Center is not responsible for damage to any item taken into the MRI scan room.

Please note on the drawing below the location of any metal inside your body [clips pins, nails, rods, staples, metal implants]

RIGHT LEFT



The following questions must be answered before the exam is Performed:

_____Do you have a cardiac pacemaker?
_____ Have you ever had chest or heart surgery?
_____Do you have Stents of Filters anywhere in your body?
_____Have you ever had brain surgery?
_____Do you have an aneurysm clip in your brain?
_____Do you have an inner ear implant?
_____Do you have a neural stimulator implant?
_____Do you have any other implanted devices in your body?
If yes, please explain _____
_____Have you ever had any metal your eye?
_____Are you pregnant?
_____Are you breast-feeding?
_____Have you had any surgery in the last six (6) weeks?
_____Have you ever had back surgery?
_____Do you have a history of cancer or tumor?
_____Claustrophobia (fear of closed space)
_____Have you ever had a liver transplant?
_____Are you a diabetic?
_____Do you a history of Renal (Kidney) disease or have only one Kidney?
_____Do you have a personal history of renal (Kidney) failure?
_____ Do you have any temporary devices on your body such as a hearing aid / heart monitor / neural stimulator / removable appliance?

Do you fully understand the questions that you have answered? _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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