

**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: _____

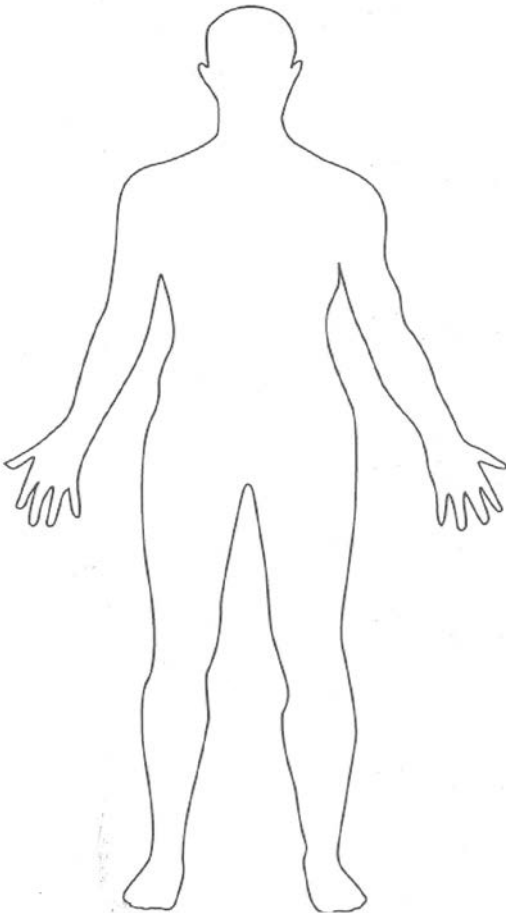
PATIENT SCREENING & HISTORY

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 or 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: _____