ANGELO MRI

Your health. **Your Choice.** Your MRI.

PATIENT SAFETY SCREENING QUESTIONNAIRE

DO YOU HAVE A PACEMAKER OR STIMULATOR? ___YES ___NO IF YES, PLEASE INFORM US BEFORE COMPLETING THIS FORM!

Date_____

Name _____

Gender _____ DOB _____ Age ____ Height _____ Weight _____

Have you had any previous exams pertaining to the body part being scanned today? Please circle.

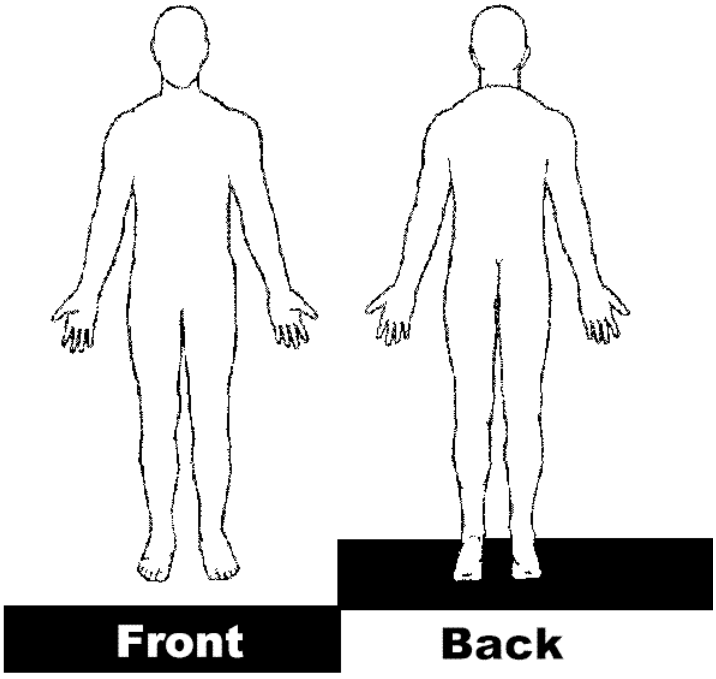
___ MRI ___ CT ___ X-rays ___ Ultrasound ___ Bone scan

Where was your previous MRI scan conducted? _____

What is the nature of your injury and/or pain? _____

_____

Please mark where you are experiencing pain or other issues.



The following items may be harmful to you during your MRI scan or may interfere with it. If you answer YES to any of the questions below, please discuss any concerns and/or issues you may have with the MRI Technologist.

Please check YES or NO to the following:

YES NO

___ ___ Do you have stents?
___ ___ Have you had heart surgery?
___ ___ Have you had surgery on your head?
___ ___ Do you have any implants in your body?
___ ___ Do you have ear or eye implants?
___ ___ Do you have any surgical clips?
___ ___ Do you have fillings, dentures, etc.?
___ ___ Do you wear hearing aids?
___ ___ Do you have metal inside your body?
___ ___ Do you have metal in your eyes from welding?
___ ___ Do you have a tattoo, body piercing, or permanent makeup?
___ ___ Do you wear a wig or have hair transplants?

Please check YES or NO to answer the following history information:

YES NO

___ ___ Kidney disease
___ ___ Diabetes
___ ___ Liver disease
___ ___ Claustrophobia
___ ___ Drug allergy, type(s):
___ ___ Latex allergy
___ ___ Allergic reaction to Gadolinium-based MRI contrast
___ ___ Other allergies: _____

Are you on dialysis?

YES NO

___ ___ If yes, Hemodialysis or Peritoneal? Please circle one.

Female:

Are you pregnant?

YES NO

___ ___

Are you breast feeding?

YES NO

___ ___

We provide headphones for you to wear during the scan. Please tell us what radio station or Pandora artist you would like to listen to, and we will accommodate your request. _____

I, the patient, or the legally authorized representative of the patient, do hereby consent to the performance of medical diagnostic and imaging procedures at Angelo MRI. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make the decision whether or not I, or the patient, should undergo the procedure. By signing below, I hereby certify that I have fully read this consent, had it explained to me, or have had it read to me, and have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

_____ _____ _____
Patient/Parent/Guardian Signature Date Time

_____ _____ _____
Printed Name Date Time

_____
Relationship to Patient

_____ _____ _____
Technologist Signature Date Time

ANGELO MRI TECHNOLOGIST NOTES: