OPTIMA DIAGNOSTIC IMAGING

CT • MRI • PET/CT • BONE SCAN

MRI QUESTIONNAIRE

Name: _____ Age: _____ Weight: _____

Referring Physician: _____

Known Allergies: _____

Screening Contraindications (*MRI scan can not be performed*)

Pacemaker	(Yes / No)		
Metal in Eye	(Yes / No)	Cochlear Ear Implants	(Yes / No)

Screening Potential Contraindications *(Can be done with screening X-ray, removal or doctor's special approval)*

Pregnant	(Yes / No)	Infusion Pump (external)	(Yes / No)
Insulin Pump	(Yes / No)	Chemotherapy Pump	(Yes / No)
Implanted Electrodes	(Yes / No)	Other Implanted Infusion Pump	(Yes / No)
		Cerebral Aneurysm Clips	(Yes / No)

Additional Patient Information

Do you have any metal in your body? (Yes / No) Are you Claustrophobic (Yes / No)

If yes, explain: _____

If you had neck or back surgery, what level was operated on? _____

Briefly describe your symptoms in relation to today's MRI: _____

_____

If you are having an MRI on your spine, please mark (circle) where the pain is located:

Neck	Right	Center	Left
Mid-Back	Right	Center	Left
Lower Back	Right	Center	Left

Does this pain go down your:

Arm	Right	Left
Leg	Right	Left
Other _____	Right	Left

Do you have an appointment with your doctor today immediately following this examination? Yes / No

To protect the privacy of other patients and provide the highest level of medical care, relatives and friends are not allowed in the control area.

Signature: _____

PLEASE REMOVE ALL JEWELRY !

8/2009

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QUESTIONNAIRE FOR MUSCULOSKELETAL PATIENTS

Name: _____ Date: _____
Age: _____ Date of Birth: _____ M / F (please circle): Phone #: (___)_____
Referring Physician: _____

1. Area to be scanned: Right _____ Left _____
   Ankle ____ Elbow _____ Hip ____ Knee _____ Shoulder ____ Wrist _____
   Other (specify): _____

2. What is your main symptom? (pain, limited movement, etc.) _____
   _____
   How long has this area been a problem? _____
   Is the problem related to any injury? No ____ Yes ____ Unknown _____
   If yes, date of injury? _____
   Type of injury? _____

   Is this a sports injury? No ____ Yes ____ Unknown _____
   Which sport? _____

3. Have you had surgery in this area? No ____ Yes ____
   If yes, date of surgery? _____
   Type of surgery? _____
   Where was surgery performed? _____
   Have you had any other surgeries? _____

4. Do you have any medical problems such as diabetes, arthritis, gout or kidney disease? Please list all:
   _____
   _____

5. Previous imaging studies of this area (please indicate the date of the most recent exam for each category):

	NO	YES	DATE	WHERE DONE?
Radiographs (X-rays)				
Arthrogram				
CT Scan				
Radioisotope Bone Scan				
MRI				
Other (type): _____				

6. When is the next appointment with your referring physician? _____

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Consent Form For The Use Of Contrast Material For Magnetic Resonance Imaging (MRI)

(Gadolinium)

Your doctor has asked us to perform an MRI examination with contrast material. This form is meant to inform you of some of the possible risks involved in the utilization of contrast material.

Contrast material is a clear liquid, which is administered to you by intravenous injection. In general, we use this material to improve the sensitivity and specificity of your examination.

In the past few years that this contrast material has been used, there have been a few serious reactions to the material. The problems encountered have been mild transient headaches, nausea, localized pain at the site of the injection and, very rarely, a rash.

A very rare fibrosing condition of the skin and organs can occur which appears to be higher in patients receiving MRI with gadolinium, particularly when the kidneys are not functioning properly. Although rare, it can cause permanent disability and death. Every effort will be made to minimize these risks by staff obtaining a thorough medical history and having it reviewed by the supervising physician.

We are aware of the risk involved in these procedures and try to take every precaution to obtain satisfactory examinations with maximum safety to the patient.

Acknowledgement:

By signing this form, you agree that you (1) have read and understood the information in this form; (2) have been verbally informed about the administration of the Contrast material; (3) have had an opportunity to ask questions and have received all the information you desire concerning the Contrast material; (4) understand the potential risks, benefits, and alternatives of the Contrast material; (5) have been informed that you may revoke your consent at any time without effecting future treatment; and (5) consent to and authorize Optima Diagnostic Imaging to administer the Contrast material in connection with the procedure.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Signature of Witness Date