



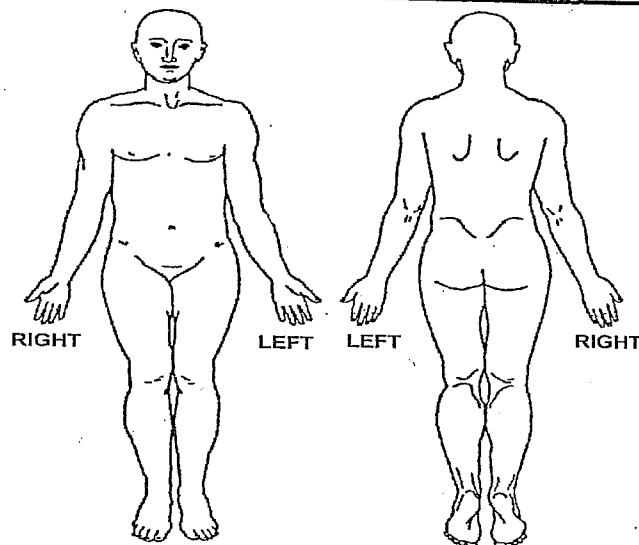
ORTHOPAEDIC SPECIALISTS

OF NORTHWEST INDIANA

Please indicate if you have any of the following:

- | | | |
|--|-----------------------------|--|
| ☐ Yes | ☐ No | Aneurysm clip(s) |
| ☐ Yes | ☐ No | Cardiac pacemaker |
| ☐ Yes | ☐ No | Implanted cardioverter defibrillator (ICD) |
| ☐ Yes | ☐ No | Electronic implant or device |
| ☐ Yes | ☐ No | Magnetically-activated implant or device |
| ☐ Yes | ☐ No | Neurostimulation system |
| ☐ Yes | ☐ No | Spinal cord stimulator |
| ☐ Yes | ☐ No | Internal electrodes or wires |
| ☐ Yes | ☐ No | Bone growth/bone fusion stimulator |
| ☐ Yes | ☐ No | Cochlear, otologic, or other ear implant |
| ☐ Yes | ☐ No | Insulin or other infusion pump |
| ☐ Yes | ☐ No | Implanted drug infusion device |
| ☐ Yes | ☐ No | Any type of prosthesis (eye, penile, etc.) |
| ☐ Yes | ☐ No | Heart valve prosthesis |
| ☐ Yes | ☐ No | Eyelid spring or wire |
| ☐ Yes | ☐ No | Artificial or prosthetic limb |
| ☐ Yes | ☐ No | Metallic stent, filter, or coil |
| ☐ Yes | ☐ No | Shunt (spinal or intraventricular) |
| ☐ Yes | ☐ No | Vascular access port and/or catheter |
| ☐ Yes | ☐ No | Radiation seeds or implants |
| ☐ Yes | ☐ No | Swan-Ganz or thermolulution catheter |
| ☐ Yes | ☐ No | Medication patch (Nicotine, Nitroglycerine) |
| ☐ Yes | ☐ No | Any metallic fragment or foreign body |
| ☐ Yes | ☐ No | Wire mesh implant |
| ☐ Yes | ☐ No | Tissue expander (e.g., breast) |
| ☐ Yes | ☐ No | Surgical staples, clips, or metallic sutures |
| ☐ Yes | ☐ No | Joint replacement (hip, knee, etc.) |
| ☐ Yes | ☐ No | Bone/joint pin, screw, nail, wire, plate, etc. |
| ☐ Yes | ☐ No | IUD, diaphragm, or pessary |
| ☐ Yes | ☐ No | Are you here for an MRI examination? |
| ☐ Yes | ☐ No | Dentures or partial plates |
| ☐ Yes | ☐ No | Tattoo or permanent makeup |
| ☐ Yes | ☐ No | Body piercing jewelry |
| ☐ Yes | ☐ No | Hearing aid |
| <i>(Remove before entering MR system room)</i> | | |
| ☐ Yes | ☐ No | Other implant _____ |
| ☐ Yes | ☐ No | Breathing problem or motion disorder |

DOB: ____/____/____	Weight: _____
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NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____

Signature

Date ____/____/____

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse _____

Print name

Relationship to patient

Form Information Reviewed By: _____

NAME: _____ DATE OF BIRTH: ____/____/____ DATE: ____/____/____

REASON FOR EXAM

Contrast Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MRI examination. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headaches or nausea), and serious or life-threatening reactions may occur.

I have read and understand the above information, and have had my questions answered. I agree to have the MRI procedure and injection of contrast if deemed necessary.

History of previous reactions?

Name of Contrast: _____ Lot: _____

If yes, explain: _____ Amount: _____ Exp. Date ____/____/____

Patients stated weight: _____ Injection Site: _____

Injected by: _____

Signature of Patient (Parent of Guardian): _____ Date: ____/____/____

Tech Comments _____

Prior to release, patient was assessed and found impaired? Yes or No
If yes, supervising Physician notified Yes or No

☐ Post injection instructions given (applicable to all patients who receive an injection)

Interviewer (Print): _____



FAX TRANSMITTAL

From Gretchen/Angie/Tessa

Pages including cover:

Patient Name/DOB: _____

Date: ____/____/____

Diagnosis:

Comments:
