VASCULAR INTERVENTIONAL SPECIALISTS | CORA

MRI PATIENT INFORMATION

Location of your exam

- ☐ **Central Oregon Radiology, Assoc., P.C.**
- ☐ **Cascade Medical Imaging, LLC - Redmond**
- ☐ **Cascade Medical Imaging, LLC - Bend/South Side**
- ☐ **SCHC: ☐Bend ☐Redmond ☐Madras ☐Prineville**

Today's Date: _____/_____/_____

Name: _____ _____ _____ ☐ Male ☐ Female _____
Last First MI Age

DOB:_____ Height_____ **Weight _____ Referring Physician: _____

In the interest of safety, we require that all patients change into a gown for their MRI exam. Additionally, you cannot bring any valuables into the scanning room (including credit cards) so the technologist will lock these up for you outside of the room.
***** Your accurate weight is important!*** **You may be weighed by the technologist prior to your exam. If your weight exceeds 350 lbs. an alternate study may be recommended by your physician.**

Briefly describe the problem(s) you are experiencing that made you see your doctor: _____

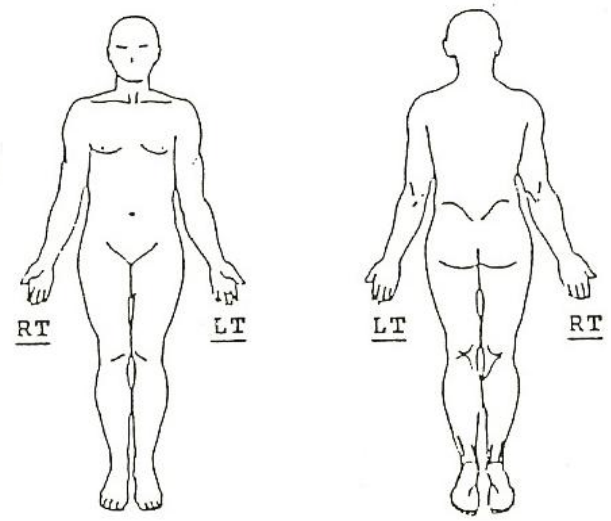
☐ Yes ☐ No Have you had any surgery related to your current problem(s)?

☐ Yes ☐ No Do you have a personal history of cancer in any part of your body?

What part of your body and when was this diagnosis made? _____

PERTINENT PREVIOUS STUDIES:	WHEN and WHERE WERE THEY PERFORMED?
X-rays	
Computed Tomography also known as (CT) (CAT Scan)	
Ultrasound	
Nuclear Medicine	
MRI	

Please use this diagram to mark where you are feeling pain:



PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

FOR OFFICE USE ONLY

PLACE MEDI-TAPE STICKER HERE

THE FOLLOWING ITEMS MAY BE POTENTIALLY HAZARDOUS AND YOU MAY NOT QUALIFY FOR YOUR MRI SCAN. PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

☐ Yes ☐ No Cardiac pacemaker or pacemaker wires/defibrillator/cardiac monitor?
☐ Yes ☐ No Brain aneurysm clip/coil?
☐ Yes ☐ No Implanted pumps/electronic devices?
☐ Yes ☐ No Neurostimulator or mechanical bone growth stimulator?
☐ Yes ☐ No Do you have any ☐ Middle ear implant ☐ hearing aids?
☐ Yes ☐ No Any type of intravascular ☐ coil ☐ filter ☐ stent ☐ shunt ☐ heart valves?
☐ Yes ☐ No Diaphram/IUD or Penile prosthesis (implant)?
☐ Yes ☐ No Permanent eyeliner by tattoo?
☐ Yes ☐ No Specific braces device (Palate expander or Herbst Device)?
☐ Yes ☐ No Are you pregnant or do you suspect that you may be pregnant?
☐ Yes ☐ No Breast Tissue Expanders (other than implants)?
☐ Yes ☐ No Any metallic foreign body, shrapnel, bullet?
☐ Yes ☐ No Have you ever had metal in your eyes? Example: From welding, grinding or other metal work?
If yes was it completely removed? ☐ Yes ☐ No
☐ Yes ☐ No Do you have any other metal or electronic devices not listed?
☐ Yes ☐ No Do you have piercings/jewelry that have not been removed?

Do you have **ANY** of the following conditions:

☐ Yes ☐ No Are you on dialysis or do you have a history of kidney failure?
☐ Yes ☐ No Have you had a kidney removed?
☐ Yes ☐ No Are you a diabetic?
☐ Yes ☐ No Do you have a history of cancer treated with Chemotherapy?
☐ Yes ☐ No Do you have a history of heart disease?
☐ Yes ☐ No Are you older than 70?
☐ Yes ☐ No Do you have a history of long standing or poorly controlled hypertension?

MRI is usually a very safe medical procedure; however, MRI employs a strong magnet that can move metallic objects within patients. Such movement of metallic objects can have serious consequences for the patient. Please complete this screening form thoroughly to determine if it is safe for you to have an MRI.

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. I hereby give my consent to having a Magnetic Resonance Imaging (MRI) scan including the administration of contrast material if indicated.

Patient or Guardian's Signature: X _____ Date: _____/_____/_____

Print Patient's Name: X _____

Radiographer's Signature: _____

Radiographer - Screening Films Done for Questionable Foreign Body in Orbit(s) ☐ Yes ☐ No

I understand that I am requesting services from Central Oregon Radiology Assoc., P.C. and or Central Oregon Magnetic Resonance Imaging, LLC that may not be approved or covered by my insurance company. Authorization is not a guarantee of payment. Claims payment will be based on member eligibility, medical necessity and benefits in effect at the time of service. I am agreeing to pay for these services personally if these services are not approved or covered.

Patient or Responsible Party Signature: X _____ Date: _____/_____/_____

Witness Signature: X _____ Date: _____/_____/_____

E.R. Physicians consent for emergency MRI services. Patient unable to conset X _____ Date: _____/_____/_____

Print E.R. Physician's Name X _____ Date: _____/_____/_____