MRI
DEPARTMENT

Please Print

JEWETT ORTHOPAEDIC CLINIC
ESTABLISHED 1936
Over 65 Years of Orthopaedic Leadership

For Office Use Only
Date _____
Account # _____
F/U Appt w/Ref MD _____

NAME _____ SOCIAL SECURITY # _____
Last, First, Middle

AGE _____ BIRTHDATE _____ HEIGHT _____ WEIGHT _____ SEX: ❑ M ❑ F

EMERGENCY CONTACT: NAME _____ NUMBER _____

FEMALES: Are you pregnant? ❑ YES ❑ NO When was your last menstrual period? _____Are you breastfeeding?_____

REFERRING JEWETT PHYSICIAN _____

Briefly describe your problem/pain and how long you have had these symptoms? _____

_____

DATE OF INJURY (IF APPLICABLE) _____

HAVE YOU HAD **SURGERY OR RADIATION THERAPY** IN THE AREA TO BE SCANNED? ? ☐ YES ☐ NO

IF YES, DESCRIBE WHAT WAS DONE AND WHEN THE SURGERY WAS PERFORMED _____

_____

IF SURGERY, ARE YOUR SYMPTOMS : BETTER WORSE SAME DIFFERENT (CIRCLE AND DESCRIBE)

_____

HAVE YOU HAD ANY OF THE FOLLOWING STUDIES PERTAINING TO TODAYS EXAM? IF SO, INDICATE BELOW.

TEST	WHEN	WHAT FACILITY	RESULTS
X-rays			
CT Scan			
MRI Scan			
Ultrasound			
Nuclear Medicine			
Therapeutic Injection			
Arthrogram			

INDICATE SYMPTOMS:

Please check:	RIGHT	LEFT	BOTH
Arm Pain	☐	☐	☐
Neck Pain	☐	☐	☐
Back Pain	☐	☐	☐
Leg Pain	☐	☐	☐
Tingling	☐	☐	☐
Weakness	☐	☐	☐
Numbness	☐	☐	☐

PAIN LOC: _____

DURATION: _____

SURG: _____

PREVIOUS IMAGING: _____

INJURY DATE: _____

ADD. INFO: _____

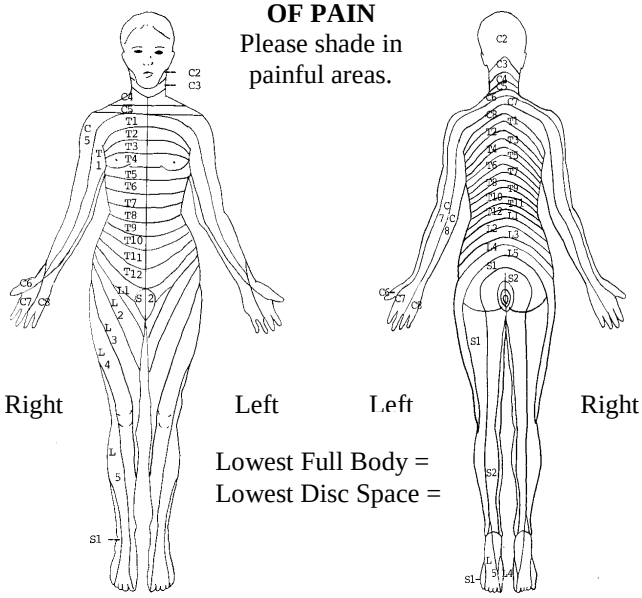
Revised 08/17/05 JL

C2/3 =
C3/4 =
C4/5 =
C5/6 =
C6/7 =
C7/T1 =
T12/L1=
L1/2 =
L2/3 =
L3/4 =
L4/5 =

FRONT

LOCATION OF PAIN
Please shade in painful areas.

BACK



Right Left Left Right

Lowest Full Body =
Lowest Disc Space =

T1/2 =
T2/3 =
T3/4 =
T4/5 =
T5/6 =
T6/7 =
T7/8 =
T8/9 =
T9/10 =
T10/11 =
T11/12 =
T12/L1 =

JEWETT ORTHOPAEDIC, P.A. - MRI Check List

Dear Patient – <u>Please answer these questions carefully!</u> Your answers to the following questions will help us to determine whether this MRI examination is safe for you based on your history. In addition, we need to determine whether the items asked below may interfere with your study or may cause difficulty with the scan results. Please indicate your answer for each of the following questions to the best of your knowledge.

Do you have a cardiac (heart) pacemaker or wires?	❒ YES	❒ NO
Do you have an internal defibrillator in your heart?	❒ YES	❒ NO
Do you have an artificial heart valve?	❒ YES	❒ NO
Do you have any aneurysm clips or metal clips in your body or head?	❒ YES	❒ NO
Do you have an implanted neurostimulator (TENS) units?	❒ YES	❒ NO
Do you have any type of biostimulator or bone growth stimulator? If yes, type:	❒ YES	❒ NO
Do you have any type of intravascular coil, filter or stent (i.e., Gianturco coil, Gunther IVC filter, Palmaz stent, etc.)?	❒ YES	❒ NO
Do you have any implanted orthopedic (bone) items i.e., pins, screws, nails, clips, plates, wires, or artificial limbs or joints?	❒ YES	❒ NO
Do you have an orbital or eye prosthesis?	❒ YES	❒ NO
Do you have any personal history of asthma, bronchitis, or emphysema?	❒ YES	❒ NO
Do you have a middle ear prosthesis, cochlear implant, or have you had ear surgery?	❒ YES	❒ NO
Do you have any known or possible metal fragments in the eye, head, or body? SPECIAL ATTENTION TO: Welding, metal grinding, machinists, and sheet metal workers)	❒ YES	❒ NO
Have you had a procedure within the past week where you swallowed a special "gastric capsule camera" that is used to look inside your stomach or intestines?	❒ YES	❒ NO
Do you have any type of implant held in place by a magnet (i.e., dentures)? If yes, what type:	❒ YES	❒ NO
Do you have a vascular access port?	❒ YES	❒ NO
Do you have any permanent tattoos, permanent eyeliner* or body piercing? (* A small percentage of patients with tattooed eyeliner have experienced transient skin irritation in association with MRI. You may want to discuss this matter with your imaging technologist.)	❒ YES	❒ NO
Do you have or are you wearing a hearing aid?	❒ YES	❒ NO
Are you claustrophobic?	❒ YES	❒ NO
Do you have a medication patch in place?	❒ YES	❒ NO
Do you have any personal history of cancer? If yes, what type?	❒ YES	❒ NO
Do you have any allergies? If yes, to what:	❒ YES	❒ NO
Are you diabetic? If yes, do you have an insulin pump?	❒ YES	❒ NO
Do you have any kidney disease? Yes or No If yes, are you on dialysis?	❒ YES	❒ NO
Have you ever had an injection of contrast (dye) for an MRI? If yes, did you have any type of reaction?	❒ YES	❒ NO
Do you have any other medical problems? (Please list): _____	❒ YES	❒ NO
For MRI Lumbar, Cervical, Thoracic. Have you had surgery on the area being scanned? If yes, add contrast	❒ YES	❒ NO
FEMALES ONLY:		
Are you pregnant?	❒ YES	❒ NO
Are you currently breast-feeding?	❒ YES	❒ NO
Do you have an inflatable breast implant or tissue expander implants?	❒ YES	❒ NO
Do you have an IUD in place?	❒ YES	❒ NO
MALES ONLY:		
Do you have a penile prosthesis?	❒ YES	❒ NO
Do you have a tissue expander implant?	❒ YES	❒ NO

For your information: As a routine part of your MRI exam, a contrast agent called "gadolinium" may be used to help enhance the areas being scanned. The most common side affects to this contrast agent are headache (less than 10%) and nausea (less than 5%).
I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient or Guardian Signature:_____ **Date:**_____/_____/_____

Revised 11-02-04 (F:Forms/CDI Metal Checklist.Patient)