Norris, Blessinger & Woebkenberg
Orthopaedics & Spine
1900 Saint Charles Street • Jasper, IN 47546 • 812-634-1211

MRI HISTORY AND SCREENING FORM

Patient Name: _____ **Date:** _____

Sex: ☐ **Male** ☐ **Female** **Height:** _____ **Weight:** _____ **Birth Date:** ____/____/_____

Reason you are here today? Explain your medical problem. (What is the problem? Where is the problem? Etc...)

_____

_____

Have you taken any sedation/medication today to relax you for this procedure? ☐Yes ☐ No If yes, what?_____

If yes, do you have someone to drive you home? ☐ Yes ☐ No

Do you have or have you ever had any of the following? (Please provide details for any "yes" answers)

☐ **Yes** ☐ **No** **Cardiac Pacemaker:** _____

☐ **Yes** ☐ **No** **Heart Surgery/Heart Valve: If Yes, explain:**_____

☐ **Yes** ☐ **No** **Implanted Cardiac Defibrillator (ICD) :** _____

☐ **Yes** ☐ **No** **Brain Aneurysm Clips/ Brain Surgery: If Yes, explain:** _____

☐ **Yes** ☐ **No** **Shunts/Stents/Filters/Intravascular Coil:**_____

☐ **Yes** ☐ **No** **Eye Surgery/Implants/Spring/Wires/Retinal Tack:** _____

☐ **Yes** ☐ **No** **Injury to the Eye Involving Metal or Metal Shavings:** _____

☐ **Yes** ☐ **No** **Orthopedic Pins/Screws/Rods/Joints/Prosthesis:** _____

☐ **Yes** ☐ **No** **Neurostimulator/Biostimulator:** _____

☐ **Yes** ☐ **No** **Previous Back Surgery (Lumbar/Thoracic/Cervical): When:**_____ **Levels:**_____

☐ **Yes** ☐ **No** **Ear Surgery/Cochlear Implants/Hearing Aids/Stapes Prosthesis:** _____

☐ **Yes** ☐ **No** **Vascular Access Port/Catheter:** _____

☐ **Yes** ☐ **No** **Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes:** _____

☐ **Yes** ☐ **No** **Electrical/Mechanical/Magnetic Implants? Type:** _____

☐ **Yes** ☐ **No** **Implanted Drug Infusion Pump/Insulin Pump:** _____

☐ **Yes** ☐ **No** **Are you Pregnant or could you be Pregnant?:**_____

☐ **Yes** ☐ **No** **Tattoo's/Permanent Make-up/Body Piercing/Patches:** _____

☐ **Yes** ☐ **No** **Dentures/Partials/Dental Implants:** _____

☐ **Yes** ☐ **No** **Gunshot Wounds/Shrapnel/BB:** _____

☐ **Yes** ☐ **No** **Do you have pins in your Hair/Clothes/Hair Extensions/Hair Pieces/Wig:** _____

List any Drug Allergies: _____

I attest that the above information is correct to the best of my knowledge. I have also informed the technologist that I am not pregnant at this time. I acknowledge I have had the opportunity to ask questions related to this form, to ask questions regarding the MRI procedure, and I understand the information presented to me.

_____ _____ _____

Patient/Parent/Legal Guardian **MRI Technologist's Signature** **Date**

WARNING: The MRI System has a very strong magnetic field that may be hazardous to you if you have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. **Please be sure to remove** all metallic objects before entering the MRI room. These objects include: hearing aids, pagers, cell phones, keys, watches, credit/debit/ID cards with magnetic strips, hair pins, eye glasses, jewelry, pocket knives, steel toe boots/shoes, tools, coins, pens, etc. Please discuss any questions or concerns with the MRI Technologist **BEFORE** entering the MRI Room.

MEMORIAL HOSPITAL
And Health Care Center
Sponsored by the Little Company of Mary Sisters -USA

My MRI exam today will be interpreted by a Radiologist from Memorial Hospital and Health Care Center (MHHCC). Therefore, MHHCC will bill for the reading of my MRI. I understand all accounts are the full responsibility of the patient and/or patient's responsible party/guarantor. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to MHHCC. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to MHHCC on my behalf. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

I authorize MHHCC Radiology to disclose and release by telephone, fax, mail, or electronic transmission all or part of my medical record and information regarding this examination. This information may be released to any onsite reviewer, my health insurance carrier, workers' compensation board or their agents, employees and/or representatives, home health agency, residential center or nursing home. I understand that I may revoke this authorization any time by notifying MHHCC Radiology. Otherwise, this authorization will remain in effect after my examination is completed.

Patient Signature: _____ Date: ___/___/___

Parent/Guardian: _____ Date: ___/___/___