



MRI QUESTIONNAIRE

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Sex: M F Last First Middle Initial

Weight Height Age Birthdate

Referring Physician: \_\_\_\_\_

If Female, Date of Last Menstrual Period: \_\_\_\_\_

Type of Study Ordered: \_\_\_\_\_

Do you have any history of cancer? YES NO If YES, what type? \_\_\_\_\_

Please indicate any previous exams relating to this injury or illness (Circle all that apply)

MRI CAT Scans X-Rays Lab Test

Please describe the symptoms of your injury or illness: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please circle YES or NO for each statement below:

- I am claustrophobic YES NO
I get very nervous at times YES NO
I have ear implants YES NO
I have had head surgery YES NO
I have had other surgeries YES NO
I have a pacemaker YES NO
I have had metal in my eyes YES NO
I have a prosthesis YES NO
I am or may be pregnant YES NO
I am currently breast feeding YES NO
I have sickle cell anemia YES NO
I have blood disorders YES NO
I had a previous CAT Scan YES NO
I had a previous MRI YES NO
I have intracranial clamps YES NO
I have metallic implants YES NO
I use a hearing aid YES NO
I have dentures YES NO
I have drug allergies YES NO
I have had liver disease YES NO
I have a mechanical heart valve YES NO
I have carotid clamps YES NO
I have intravascular stints, coils or filters YES NO
I have shrapnel in or near my eyes or Spine (BBs in Body) YES NO
I have an Insulin Pump Neurostimulator YES NO
I have a Tens Unit YES NO
I have a Holter Monitor or Defibrillator YES NO
I have a tissue expander w/magnetic port YES NO

(Continued on reverse side)

If you answered YES to any of the previous questions, please explain in detail.

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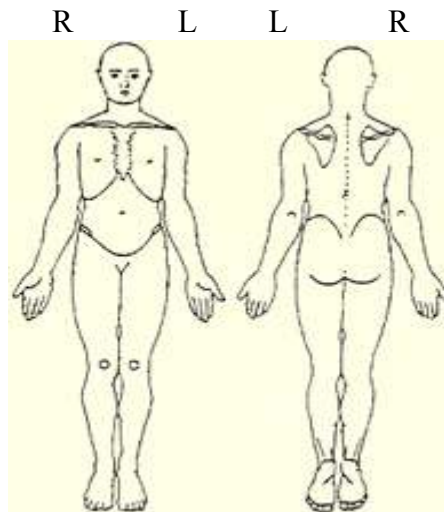
Please describe any other medical history information you think we should know about.

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Draw on these figurines where your pain symptoms are located  
Circle symptoms

- |           |              |
|-----------|--------------|
| Pain      | Speech       |
| Numbness  | Confusion    |
| Tingling  | Seizures     |
| Burning   | Hearing Loss |
| Headaches | Balance      |
| Weakness  | Walking      |
| Visual    | Memory       |



I have answered these questions to the best of my knowledge and understand the information presented to me.

Patient/Parent/ Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Technologist/Witness Signature: \_\_\_\_\_

<b>TECHNOLOGIST USE ONLY:</b>				
_____ CC of Magnevist with a _____	@ _____	x _____	in _____	_____
Amount	GA & needle type	Time	# of Punctures	Site Location
By: _____	Lot: _____	Expiration Date: _____		
Contrast Reaction: YES NO Physician Covering Contrast: _____				
Comments: _____				



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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female  
(circle one)

Social Security Number: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Cell)

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Person Responsible for Bill (if other than above)**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

DOB: \_\_\_\_\_ Male Female SSN: \_\_\_\_\_  
(circle one)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Cell)

### **Insurance Information**

Primary:  
Policy Holder Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Male Female SSN: \_\_\_\_\_  
(circle one)

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ ID#/Group#: \_\_\_\_\_

Secondary:  
Policy Holder Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Male Female SSN: \_\_\_\_\_  
(circle one)

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ ID#/Group#: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(Name) (Relationship to Patient)

Phone: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
(Home) (Cell)

Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Please list below any additional Doctors you would like your report sent to:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**DOCTORS MRI  
INFORMED CONSENT FOR MRI  
WITH OR WITHOUT CONTRAST INJECTION**

**PATIENT NAME:** \_\_\_\_\_

I the undersigned, being either the patient named above or a legally authorized representative of the patient named above, do hereby consent to the performance of medical diagnostic and imaging procedures at Doctors MRI, on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make the decision whether or not to undergo the procedure.

1. **Consent to Imaging Procedure:** Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as magnetic resonance imaging (MRI) to obtain additional information that may aid in diagnosing and treating your medical condition. It has been explained to me that MRI does not use x-rays or radiation. Instead, a magnetic field and radio waves are used to create an image of internal body structures. MRI is a painless procedure that only requires that you lie quietly on a padded table that gently glides you into the magnet. While the scanner is performing your scan, you will hear some humming and thumping sounds. These are normal and should not worry you. In some cases, a contrast agent may be injected into your vein in order to give a clearer image of the area being examined. The MRI study may be conducted without the injection of contrast but the images may not be as helpful to the radiologist and your physician. Inform the technologist if you wish to refuse the contrast injection.
2. Because of the magnetic field and radio frequencies, people with a heart pacemaker, brain aneurysm clips, and some implanted metallic or electrical devices should not have an MRI. It is important that you inform the technologist if you have any of these metallic appliances. Please inform the technologist if you are pregnant or think that you may be pregnant.
3. **Potential Risks:** Anytime an injection is given there is the potential for bruising or swelling at the injection site. Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, wheezing or nausea. These symptoms may require treatment with medication we have on hand. Rarely, a more serious reaction will occur. A radiologist will evaluate the situation and determine if additional medical treatment is necessary. Even though it is rare, medical statistics indicated that a fatality might occur from the injection of contrast. If you have had a reaction to a sickle cell anemia or kidney disorder, are pregnant or breast feeding, you **MUST** inform the technologist.
4. The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however your physician believes the MRI to be the best diagnostic test for you after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

\_\_\_\_\_  
Patient/Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time