

# FONDREN ORTHOPEDIC GROUP L.L.P.

## MRI SCREENING SHEET

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

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

What body part are we doing an MRI on today? \_\_\_\_\_

How did injury occur? \_\_\_\_\_

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*Please indicate if you have any of the following.*

	YES	or	NO
Cardiac Pacemakers	<input type="radio"/>		<input type="radio"/>
Brain Aneurysm clips	<input type="radio"/>		<input type="radio"/>
Aortic clips	<input type="radio"/>		<input type="radio"/>
Implanted neurotransmitter	<input type="radio"/>		<input type="radio"/>
Insulin pump	<input type="radio"/>		<input type="radio"/>
Hearing aids	<input type="radio"/>		<input type="radio"/>
Joint Replacement-if yes, where? _____	<input type="radio"/>		<input type="radio"/>
Fractured bones treated w/ metal rods, plates, screws, nails or clips	<input type="radio"/>		<input type="radio"/>
Prosthesis	<input type="radio"/>		<input type="radio"/>
Metal slivers in eyes	<input type="radio"/>		<input type="radio"/>
Cochlear implants	<input type="radio"/>		<input type="radio"/>
Shrapnel	<input type="radio"/>		<input type="radio"/>
Are you, or think you may be pregnant?	<input type="radio"/>		<input type="radio"/>
Tattoos or body piercing	<input type="radio"/>		<input type="radio"/>
Have you ever had an MRI before?	<input type="radio"/>		<input type="radio"/>

If so, where and when \_\_\_\_\_

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**NOTE: Ensure that the following items are removed before scanning:**

- Purse, wallet, or money clip
- Jewelry
- Watch, keys, or pocket knife
- Credit Cards and bank cards with magnetic strips

List all major surgeries: \_\_\_\_\_

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

Tech Signature: \_\_\_\_\_ Date: \_\_\_\_\_