



Rock Creek Imaging

MRI Patient Assessment and Screening Form

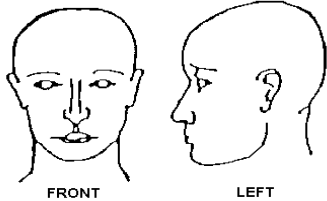
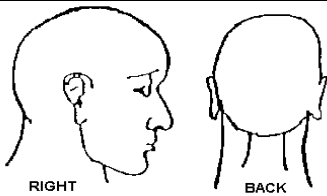
Date of Exam: _____ Time of Exam: _____ Exam Ordered: _____
 Patient Name: _____ DOB: _____ Age: _____
 Weight: _____ Height: _____ Social Security Number: _____

PATIENT HISTORY

Suitability for MRI: **MRI CANNOT** be performed if "Yes" is answered to double asterisked (**) Questions. All "Yes" single asterisked (*) are to be referred to the radiologist. For an all inclusive list of contraindications visit mrisafety.com.

** Pacemaker or Pacemaker wires	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Non Removable Hearing Aid	<input type="checkbox"/> Yes <input type="checkbox"/> No
* Allergies to: IV dye, latex, seafood, shellfish	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Metallic Foreign Body (Gun shot wounds and/or metal shavings in eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No
* Heart Stents	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
* Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	* Prior Ear or Brain Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
* Infusion Pump (Implanted)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy (Seizures)	<input type="checkbox"/> Yes <input type="checkbox"/> No
** Aneurysm clips	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattoos	<input type="checkbox"/> Yes <input type="checkbox"/> No
Disoriented	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metallic Implant/Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unable to Hold Still	<input type="checkbox"/> Yes <input type="checkbox"/> No
Orthopedic Devices	<input type="checkbox"/> Yes <input type="checkbox"/> No	Braces or Dentures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgical Clips	<input type="checkbox"/> Yes <input type="checkbox"/> No	History of Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glitter Eye Make Up	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Removable Dental Work	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Using the figure below, please shade in the areas affected by pain and/or numbness

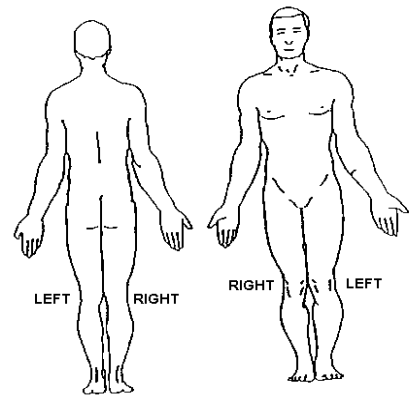


Previous MRI Yes

Previous CT Yes

Previous X-Rays Yes

If yes, Specify Area



Patient Signature: _____

Date: _____

Patient's Surgical History: