the SUMMIT
Institute for Orthopedics, Spine & Human Movement

Form # 1.0

MRI Screening Form

Name_____ _____ _____ Height_____ Weight_____
(Last Name) *(First Name)* *(M.I.)*

Birth Date____/_____/_____ Phone (H) (_____) _____ (W) (_____) _____

MRI ordering physician _____

Please list any surgeries you have had:

1._____ Year: _____ 4._____ Year:_____
2._____ Year: _____ 5._____ Year:_____
3._____ Year: _____ 6._____ Year:_____

Have you taken Valium or any other sedatives today for this exam? Yes No

Is today's visit due to an injury? Yes No
If yes, Date of injury _____

Do you have a history of Cancer? Yes No
If yes, what type? _____

Is there any chance that you are pregnant? Yes No
Are you breast-feeding? Yes No

Do you have any of the following devices or conditions?
Note: Some of the following can interfere with, or prohibit you from having an MRI. The technologist will discuss this with you, if any of the following apply:

- o Cardiac Pacemaker/Defibrillator Yes No
- o Eye Injury/Metal in Eyes Yes No
- o Leads/Heart Valve Replacement Yes No
- o Aneurysm/Brain Clip(s) Yes No
- o Neuro/Bone Stimulator Yes No
- o Cochlear/Inner Ear Implants Yes No
- o Insulin/Infusion Pump Yes No
- o Prosthesis (Eye, Penile, etc.) Yes No
- o Intravascular Stents, Filters, or Coils Yes No
- o Shunt (Spinal or Intraventricular) Yes No
- o Vascular Accessed Port Yes No
- o Permanent Tattooed Makeup Yes No
- o Transdermal Delivery System (Nitro) Yes No
- o IUD (Intra Uterine Device) Yes No
- o Any Metal Fragments Yes No
- o Hearing Aids Yes No
- o Dentures Yes No
- o Body Piercing(s) Yes No
- o Other, Please Explain_____

Signature_____ Date _____

Revised 03/2012