1640 Hospital Drive, Santa Fe, NM 87505
TEL: 505-983-9350 ▪ FAX: 505-954-4253

SANTA FE IMAGING

MRI PATIENT SCREENING FORM

PATIENT NAME _____

DOB _____ **AGE** _____ **WEIGHT** _____ **HEIGHT** _____

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

REFERRING PHYSICIAN _____

EXAM ORDERED _____

▪ **DESCRIBE YOUR PROBLEM & HOW LONG YOU HAVE HAD IT** _____

_____

_____

▪ **PLEASE LIST ANY OTHER HEALTH PROBLEMS (i.e., Cancer, Diabetes, etc.)** _____

_____

_____

▪ **PLEASE LIST AND GIVE DATES FOR ANY SURGERIES** _____

_____

_____

_____

▪ **ARE YOU PREGNANT?** _____ **YES** _____ **NO** _____ **NA**

▪ **DO YOU HAVE ANY ALLERGIES?** ____ **YES** **NO**

IF YES, PLEASE LIST _____

_____

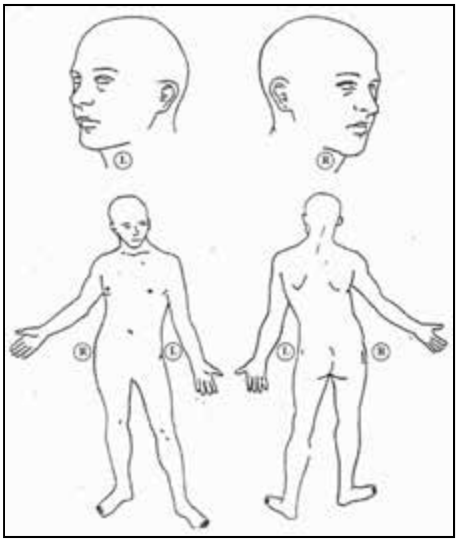
PLEASE CIRCLE BELOW ANY PREVIOUS EXAMS <u>THAT RELATE TO TODAY'S TESTS.</u>

MRI CT X-RAYS ULTRASOUND BONE SCAN PET / CT

WHERE DID YOU HAVE THE EXAM(S)? _____

_____

_____



Please mark area(s) in which you are experiencing pain

PLEASE COMPLETE <u>BOTH SIDES</u> OF THIS FORM

1640 Hospital Drive, Santa Fe, NM 87505
TEL: 505-983-9350 ▪ FAX: 505-954-4253

SANTA FE IMAGING

MRI PATIENT SCREENING FORM (PART 2)

THE FOLLOWING QUESTIONS ARE ESSENTIAL FOR THE QUALITY AND SAFETY OF YOUR MRI EXAMINATION

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Cardiac pacemaker	YES	NO	Any metal in eyes	YES	NO
Internal electrodes or wires	YES	NO	Orbital /eye prosthesis	YES	NO
Aneurysm clip	YES	NO	Eyelid spring or wire	YES	NO
Aortic or carotid clip	YES	NO	Cochlear or ear implant	YES	NO
Implanted cardio defibrillator	YES	NO	Hearing aid	YES	NO
Metal or electronic implant	YES	NO	Surgical staples / metallic sutures	YES	NO
Neurostimulator	YES	NO	Shrapnel or bullet	YES	NO
Implanted bio-stimulator	YES	NO	Medication patch	YES	NO
Insulin /drug infusion pump	YES	NO	IUD, diaphragm, or pessary	YES	NO
Heart valve replacement	YES	NO	Penile implant	YES	NO
Intravascular coil / stent	YES	NO	Dental braces / dentures	YES	NO
Shunt (spinal or intraventricular)	YES	NO	Tattoo or permanent makeup	YES	NO
Wire mesh	YES	NO	Acupuncture needles	YES	NO
Joint replacement (hip, knee, etc.)	YES	NO	Body piercing jewelry / Hair pins	YES	NO
Bone /joint pin, screw, plate, etc.	YES	NO	Artificial or prosthetic limb	YES	NO
Breast tissue expander	YES	NO			

***** WARNING***** Any possibility of metallic foreign material in the eyes can cause serious eye injury. If you have ever welded or used a metal grinder / drill **YOU MAY BE AT RISK**.

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I HAVE READ AND UNDERSTAND THE ENTIRE CONTENTS OF THIS FORM AND HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THE INFORMATION ON THIS FORM.

PATIENT'S / GUARDIAN'S SIGNATURE _____

DATE _____

TECHNOLOGIST NOTES (TO BE COMPLETED BY TECHNOLOGIST) _____

_____

_____

_____

_____

PLEASE COMPLETE <u>BOTH SIDES</u> OF THIS FORM