

MRI Procedure Questionnaire

Last Name:		First Name:		MRN:
				Secondary MRN:
Date of Exam:	Date of Birth:	Weight:	Referring physician:	

Previous Imaging:

Previous Diagnostic Imaging Procedure(s): **(Related to TODAY'S VISIT ONLY)**

MRI Yes No, If yes, Where: _____ When: _____

CT Yes No, If yes, Where: _____ When: _____

Personal Medical History:

History of Cancer No Yes, If yes, Type: _____

Radiation / Chemotherapy No In Progress Complete, When: _____

Reason for Today's Visit:

Symptoms: _____

How long have you had these symptoms? _____

Extremity Pain? Yes No Weakness? Yes No Numbness/tingling? Yes No

If yes, which side? Right Left

Have you had an injury? Yes No If yes, Date of Injury: _____

Describe injury: _____

Previous Surgery **(Related to TODAY'S VISIT ONLY)** Yes No, If yes, Date of surgery: _____

Type of Surgery / Describe: _____

Your signature below indicates (1) that the information you have provided on this form is true and accurate; (2) that you have received all the information that you desire concerning the diagnostic imaging procedure; and (3) that you authorize and consent to the performance of the diagnostic imaging procedure.

Signature (patient/guardian)

Date

If signed by other than patient, please indicate relationship _____

For Office Use Only- Do Not Write Below

Exam(s) Performed: _____ Previous available for comparison

STAT Report Required

Arthrogram Injection: Performed by: _____

IV Injection: Vial amount opened _____ ml Contrast: _____ cc ProHance

Right Left _____ (location) Injected by: _____

Complications: Yes No GFR: _____ Drawn Date: _____

Tech Notes: _____

Technologist Name: _____