Orlin & Cohen Medical Specialists Group
Magnetic Resonance Imaging (MRI)

Label

Please Print

Patient Name: _____, _____

LAST NAME FIRST NAME

Body Part being scanned today_____ ○ Left ○ Right ○ NA

Insurance_____**Weight** _____ **Height** ____ ft. ____in. **DOB**:_____

Certain clothing materials may cause burns, therefore you may be asked to change into appropriate patient gown.

DO YOU HAVE A CARDIAC PACEMAKER?	○ YES	○ NO
Have you ever worked with metal such as welding or grinding?	○ YES	○ NO
If yes to the above question, did you wear protective eye wear?	○ YES	○ NO
Did you ever have metal removed from either eye?	○ YES	○ NO
Have you ever had any type of surgery? If yes please specify: _____	○ YES	○ NO
_____		
Do you have any history of cancer? If yes please specify: _____	○ YES	○ NO

Do you have any of the following in or on your body?

Aneurysm clips	○ YES	○ NO	Insulin or Drug Infusion Pump	○ YES	○ NO
Body Piercing	○ YES	○ No	Intravascular Coil, Filter, or Stent	○ YES	○ NO
Bullets, BB's, or Shrapnel	○ YES	○ NO	Prosthesis (Orbital or Penile)	○ YES	○ NO
Cardiac Defibrillator	○ YES	○ NO	Removable Dental Bridges/Dentures	○ YES	○ NO
Intra-Uterine Device (IUD)	○ YES	○ NO	Tattoos or Tattooed Eyeliner	○ YES	○ NO
Hearing Aid/Cochlear Implant	○ YES	○ NO	Medication Patch	○ YES	○ NO
Loop Recorder	○ YES	○ NO	Heart Valve Replacement	○ YES	○ NO
Neurostimulator	○ YES	○ NO	Harrington Rods	○ YES	○ NO
Have you ever had an MRI of			Any Implants (i.e. joint replacement)	○ YES	○ NO
the same body part?	○ YES	○ NO			

PLEASE PROVIDE US WITH ANY DOCUMENTATION REGARDING ALL DEVICES (e.g. Implant Cards)

Female patients – Is there any possibility that you may be pregnant? ○ YES ○ NO

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire content of this form and have had the opportunity to ask questions regarding the information on this form.

_____ _____ _____

Patient Signature **Print Name** **Date**

_____ _____ ACCOUNT # _____

Relative/Guardian Relationship to Patient

Date___/___/___ Scan_____ DR/Location_____ Patient's Initials_____

Date___/___/___ Scan_____ DR/Location_____ Patient's Initials_____

FOR STAFF USE ONLY

Technologist Checklist **Technologist_____**

ANATOMY VERIFICATION

	Initials		Initials
Patient Name		Correct Exam	
Patient DOB		Scan Anatomy ❑ L ❑ Rt ❑ N/A	
Correct Modality		Confirm RX	

_____

Signature of Technologist Date