



WEST TENNESSEE BONE & JOINT CLINIC, P.C.

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MRI DATA SHEET / CONSENT FOR DIAGNOSTIC TESTING

Please fill out prior to arriving for MRI.

Patient Name: _____ Chart #: _____
 Phone Number: (Home) _____ (Work) _____
 Date of Birth: ___/___/___ Age: _____ Sex: _____ Weight: _____
 Known Drug Allergies: _____
 Ordering Physician: _____
 MRI Exam Ordered: _____
 Reason for Examination: _____
 Pain Yes No If Yes, explain: _____

History of cancer or tumor? Yes No Previous MRI? Yes No
 If so, where? _____ Previous CT? Yes No
 Previous Surgery? Yes No Previous X-rays? Yes No
 List surgeries _____
 Allergic to IV dye, latex, seafood, shellfish? Yes No

SCREENING CONTRAINDICATIONS: *(Not eligible for a MRI exam)*

*Pacemaker? Yes No Are you Claustrophobic? Yes No
 *Implanted Cardiac Defibrillator? Yes No (fear of close spaces)
 *Ever had metal in the eye? Yes No
 *Cochlear Implant? Yes No Will sedation be required? Yes No
 *Cerebral Aneurysm Yes No *if yes, medication must be ordered by physician and taken prior to MRI appointment.
 Do you have any type of internal battery operated stimulator? Yes No
 Will you be able to lie still for 20-30 minutes while the MRI exam is performed? Yes No
 Have you ever worked as a grinder or a metal worker? Yes No

MRI QUESTIONNAIRE

WARNING: The following items can interfere with MRI imaging and some can be hazardous to your safety.

Please check the appropriate boxes:

| Yes | No | Comments | Yes | No | Comments |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Head/Brain Surgery (Cerebral Aneurysm Clips)** | <input type="checkbox"/> | <input type="checkbox"/> | Eye Liner Tatoo* or Permanent Tatoo |
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Surgery* | <input type="checkbox"/> | <input type="checkbox"/> | Body Piercing - Where |
| <input type="checkbox"/> | <input type="checkbox"/> | Metal Slivers in Eye* Xray taken and OK'd by | <input type="checkbox"/> | <input type="checkbox"/> | Insulin Pump* |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery (Aortic Clips, Heart Valve)* | <input type="checkbox"/> | <input type="checkbox"/> | Infusion Pump* |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker or wires** | <input type="checkbox"/> | <input type="checkbox"/> | Wire Sutures |
| <input type="checkbox"/> | <input type="checkbox"/> | Carotid Clips** | <input type="checkbox"/> | <input type="checkbox"/> | IUD |
| <input type="checkbox"/> | <input type="checkbox"/> | Aneurysm Clips** | <input type="checkbox"/> | <input type="checkbox"/> | Ear (Cochlear) Implant** |
| <input type="checkbox"/> | <input type="checkbox"/> | Electrodes, Neurostimulators (Tens-Unit) (at present time) | <input type="checkbox"/> | <input type="checkbox"/> | Dentures |
| <input type="checkbox"/> | <input type="checkbox"/> | Shunts | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Aids |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacements Check with Radiologist | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy (at present time) |
| <input type="checkbox"/> | <input type="checkbox"/> | Metal Rods/Prosthesis | <input type="checkbox"/> | <input type="checkbox"/> | Breast Feeding (at present time) |
| <input type="checkbox"/> | <input type="checkbox"/> | Back Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Breast Implants |
| <input type="checkbox"/> | <input type="checkbox"/> | Metal Mesh* | <input type="checkbox"/> | <input type="checkbox"/> | Penile Implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Shrapnel* | <input type="checkbox"/> | <input type="checkbox"/> | Vena Cava Filters (Umbrella)* |

*=Contraindications

**=CANNOT Scan

Hair pins or other metal hair clips must be removed prior to MRI.

I have reviewed the above contraindications for having an MRI and feel that it is safe for me to have an MRI.

Patient Signature _____

Date _____

Technologist Signature _____

Date _____

