ADI H&P

	DR: Fax#	MRI: Date:

Pt. Name:		Chart #:	
Address:		DOB	
Email:		Phone:	

The below items may interfere with Magnetic Resonance Imaging (MRI) & some could be potentially dangerous Therefore, please indicate if you have any of the following & the MRI technologist will review this form with you verbally after completion. Please discuss in detail with the tech any of the below listed as "Yes".

Please check each box below appropriately:	No	Yes	>IF YES, DETAILS:
Pacemaker *If yes to pacemaker, YOU CAN NOT HAVE MRI*			
Heart Surgery (bypass, stent, valve...)			
Brain surgery or Aneurysm Clips			
Ear Surgery, Cochlear Implant or Hearing Aids			
Eye Surgery or Lens Implant (not including cataract surgery)			
Pins, Screws, Plates implanted			
Joint Replacement or Prosthetic Device			
Mechanical devices (pain pump, stimulator ...)			
Glucose Monitor			
Bullets, Pellets, or Shrapnel (gunshot or war wound...)			
Tattoo, Tattooed makeup or body piercing			
Are you pregnant or nursing?			
Any Other Implanted items (ask for our list, if necessary)			

Please describe your symptoms, pain &/or problems associated with the MRI for today:___________________

____

How long have you experienced symptoms:__________________ If you were injured, Date:________________

& circle how it occurred: Lifting Fall Sports Work Related Car Accident Other________________________

Have you ever had cancer ( )No ( )Yes> Date:__________ Type/body area:____________________________

Have you had surgery on the area we are performing the MRI( )No ( )Yes> Date & Type:_________________

Height:____________Weight:___________ (required for MRI machine)

Please indicate if you would like an emergency contact to be listed: Name & Cell:________________________

By signing, I certify that I have described my medical history correctly & I give consent for MRI at ADI

Patient signature: _________________________________ **Date:**_________________

Below For Tech Use Only

Tech Notes:		**Form Reviewed by: Tech ( ) front desk( )**
Comparison Study?	**( )Yes**	**Previous Scan: Date:**
MRI scan &CPT Code:	***Date***	***Diagnosis description:***