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# Welcome To Tri-Valley Orthopedics Specialists, Inc.
# OPEN MRI

In order to better evaluate and treat your condition, your physician feels that a Magnetic Resonance Image (MRI) is required.

Tri-Valley Orthopedics Specialists, Inc. is able to perform the MRI in our Pleasanton Office.

We must advise you that Tri-Valley Orthopedics Specialists, Inc. has ownership in this diagnostic tool, and that you have the option to choose an outside facility for your MRI. We are happy to refer you to the facility of your choice.

If you elect to have your MRI at TVO, please sign this form and return it to your Physician's Patient Care Coordinator.

Our MRI Technician, Marci, will call your insurance for authorization. Upon approval, she will then call you to schedule your appointment.

**We are unable to proceed with your MRI without this information.**

Thank you for your understanding.

____________________________________
Name (Please Print)

____________________________________
Signature Date

# MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient Number ______________________

Name ______________________________________________ Age ________ Height ________ Weight ________
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ❒ Female ❒ Body Part to be Examined _________________________
month day year

Address ____________________________________________ Telephone (home) (_____) _____-________

City ____________________________________________ Telephone (work) (_____) _____-________

State _______________________ Zip Code ___________

Reason for MRI and/or Symptoms ___________________________________________________________________________

Referring Physician __________________________________ Telephone (_____) _____-______________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❒ No ❒ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _________________________________________________________
   Date _____/_____/_____ Type of surgery _________________________________________________________
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❒No ❒ Yes
   If yes, please list:

| | Body part | Date | Facility |
|---|---|---|---|
| MRI | ______________________ | _____/_____/_____ | ________________________________ |
| CT/CAT Scan | ______________________ | _____/_____/_____ | ________________________________ |
| X-Ray | ______________________ | _____/_____/_____ | ________________________________ |
| Ultrasound | ______________________ | _____/_____/_____ | ________________________________ |
| Nuclear Medicine | ______________________ | _____/_____/_____ | ________________________________ |
| Other__________ | ______________________ | _____/_____/_____ | ________________________________ |

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❒ No ❒ Yes
   If yes, please describe: _______________________________________________________
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❒ No ❒ Yes
   If yes, please describe: _______________________________________________________
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❒ No ❒ Yes
   If yes, please describe: _______________________________________________________
6. Are you currently taking or have you recently taken any medication or drug? ❒ No ❒ Yes
   If yes, please list:_______________________________________________________
7. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ❒ No ❒ Yes
   If yes, please describe: _______________________________________________________
8. Are you allergic to any medication? ❒ No ❒ Yes
   If yes, please list:_______________________________________________________
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❒ No ❒ Yes

**For female patients:**

10. Date of last menstrual period:_____/_____/_____ Post menopausal? ❒ No ❒ Yes
11. Are you pregnant or experiencing a late menstrual period? ❒ No ❒ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ❒ No ❒ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ❒ No ❒ Yes
    If yes, please describe: _______________________________________________________
14. Are you currently breastfeeding? ❒ No ❒ Yes

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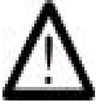
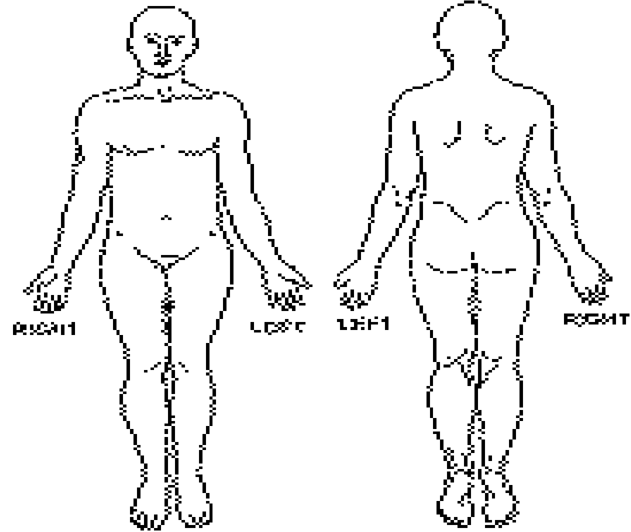


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

**Please indicate if you have any of the following:**

❒ Yes ❒ No Aneurysm clip(s)
❒ Yes ❒ No Cardiac pacemaker
❒ Yes ❒ No Implanted cardioverter defibrillator (ICD)
❒ Yes ❒ No Electronic implant or device
❒ Yes ❒ No Magnetically-activated implant or device
❒ Yes ❒ No Neurostimulation system
❒ Yes ❒ No Spinal cord stimulator
❒ Yes ❒ No Internal electrodes or wires
❒ Yes ❒ No Bone growth/bone fusion stimulator
❒ Yes ❒ No Cochlear, otologic, or other ear implant
❒ Yes ❒ No Insulin or other infusion pump
❒ Yes ❒ No Implanted drug infusion device
❒ Yes ❒ No Any type of prosthesis (eye, penile, etc.)
❒ Yes ❒ No Heart valve prosthesis
❒ Yes ❒ No Eyelid spring or wire
❒ Yes ❒ No Artificial or prosthetic limb
❒ Yes ❒ No Metallic stent, filter, or coil
❒ Yes ❒ No Shunt (spinal or intraventricular)
❒ Yes ❒ No Vascular access port and/or catheter
❒ Yes ❒ No Radiation seeds or implants
❒ Yes ❒ No Swan-Ganz or thermodilution catheter
❒ Yes ❒ No Medication patch (Nicotine, Nitroglycerine)
❒ Yes ❒ No Any metallic fragment or foreign body
❒ Yes ❒ No Wire mesh implant
❒ Yes ❒ No Tissue expander (e.g., breast)
❒ Yes ❒ No Surgical staples, clips, or metallic sutures
❒ Yes ❒ No Joint replacement (hip, knee, etc.)
❒ Yes ❒ No Bone/joint pin, screw, nail, wire, plate, etc.
❒ Yes ❒ No IUD, diaphragm, or pessary
❒ Yes ❒ No Dentures or partial plates
❒ Yes ❒ No Tattoo or permanent makeup
❒ Yes ❒ No Body piercing jewelry
❒ Yes ❒ No Hearing aid
*(Remove before entering MR system room)*
❒ Yes ❒ No Other implant ______________________
❒ Yes ❒ No Breathing problem or motion disorder
❒ Yes ❒ No Claustrophobia

**Please mark on the figure(s) below the location of any implant or metal inside of or on your body.**




## IMPORTANT INSTRUCTIONS

**Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.**

**Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.**

**NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.**

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I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: ______________________________ Date _____/_____/_____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse ______________________________ ______________________
Print name Relationship to patient

Form Information Reviewed By: ______________________________ ______________________
Print name Signature

❒ MRI Technologist ❒ Nurse ❒ Radiologist ❒ Other______________________

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