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

*Implanted Cardiac Defibrillator? ☐ Yes ☐ No

*Ever had metal in the eye? ☐ Yes ☐ No

*Cochlear Implant? ☐ Yes ☐ No

*Cerebral Aneurysm ☐ Yes ☐ No

Are you Claustrophobic? ☐ Yes ☐ No
(fear of close spaces)

Will sedation be required? ☐ 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
☐	☐	Head/Brain Surgery (Cerebral Aneurysm Clips)**	
☐	☐	Eye Surgery*	
☐	☐	Metal Slivers in Eye* Xray taken and OK'd by	
☐	☐	Heart Surgery (Aortic Clips, Heart Valve)*	
☐	☐	Cardiac Pacemaker or wires**	
☐	☐	Carotid Clips**	
☐	☐	Aneurysm Clips**	
☐	☐	Electrodes, Neurosimulators (Tens-Unit) (at present time)	
☐	☐	Shunts	
☐	☐	Joint Replacements Check with Radiologist	
☐	☐	Metal Rods/Prosthesis	
☐	☐	Back Surgery	
☐	☐	Metal Mesh*	
☐	☐	Shrapnel*	

Yes	No		Comments
☐	☐	Eye Liner Tatoo* or Permanent Tatoo	
☐	☐	Body Piercing - Where	
☐	☐	Insulin Pump*	
☐	☐	Infusion Pump*	
☐	☐	Wire Sutures	
☐	☐	IUD	
☐	☐	Ear (Cochlear) Implant**	
☐	☐	Dentures	
☐	☐	Hearing Aids	
☐	☐	Pregnancy (at present time)	
☐	☐	Breast Feeding (at present time)	
☐	☐	Breast Implants	
☐	☐	Penile Implant	
☐	☐	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 _____