



Coordinated Health Imaging

MRI Questionnaire

Patient Name: _____	Age: _____	Height: _____	Weight: _____
Body Part to be Examined: _____		Reason for MRI / Symptoms: _____	

1. Have you ever had prior surgery, operation, or procedure of any kind? YES NO

<i>If yes, please list:</i>	<i>Side (Circle One)</i>	<i>Doctor</i>	<i>Date</i>	<i>Facility (if not sure give town)</i>
Type: _____	Left /Right/Both/NA _____	_____	_____	_____
Type: _____	Left /Right/Both/NA _____	_____	_____	_____
Type: _____	Left /Right/Both/NA _____	_____	_____	_____
Type: _____	Left /Right/Both/NA _____	_____	_____	_____

2. Have you ever had a prior diagnostic imaging study or examination? YES NO

<i>If yes, please list:</i>	<i>Body Part</i>	<i>Side (Circle One)</i>	<i>Date</i>	<i>Facility (if not sure give town)</i>
MRI	_____	Left / Right / Both / NA _____	_____	_____
CT	_____	Left / Right / Both / NA _____	_____	_____
X-ray	_____	Left / Right / Both / NA _____	_____	_____
Ultrasound	_____	Left / Right / Both / NA _____	_____	_____
Nuclear Med.	_____	Left / Right / Both / NA _____	_____	_____
Other	_____	Left / Right / Both / NA _____	_____	_____

3. Have you ever experienced any problems related to a previous MRI procedure? YES NO

If yes, please describe: _____

4. Have you ever had an endoscopy or colonoscopy? YES NO

If yes, when and where? _____ Did the physician put in clips? YES NO

5. Have you ever had an injury to the eye involving a metallic object or fragment? YES NO

(metallic slivers, shavings, foreign body, etc)

If yes, please describe: _____

If yes, was it removed? YES NO

6. Are you currently working with grinding or welding metal? YES NO

7. Have you ever worked with grinding or welding metal? YES NO

For female patients:

8. Date of last menstrual period : _____
-Post menopausal? YES NO

9. Are you pregnant or experiencing a late menstrual period? YES NO

10. Are you taking oral contraceptives or receiving hormonal treatment? YES NO

11. Are you taking any type of fertility medication or having fertility treatments? YES NO

If yes, please describe: _____

12. Are you currently breastfeeding? YES NO

NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure.

Staff Use Only: Pre MRI X-ray When? _____ Where? _____



Tel: 610-865-4880
Fax: 610-997-7173

Authorization/Consent for Treatment With Contrast

1. _____ (Please initial) I authorize a qualified representative of Coordinated Health Systems to inject me with a contrast medium for the purpose of attempting to secure additional diagnostic information during my imaging study. I understand that the contrast medium injection will be done by needle and syringe into the joint or by IV.
2. _____ (Please initial). I understand that: (a) there is a remote risk of death or serious disability associated with any medical procedure; (b) the following are some other risks that may occur with this procedure: allergic reaction, bruising, swelling, nerve damage and infection; and (c) these may result in temporary or permanent injury, impairment, disability or death or the need for additional procedures.
3. _____ (Please initial). I understand that I should immediately report any feelings of discomfort that I believe may possibly be related to the injection to a qualified representative of Coordinated Health Systems. I also understand that I should immediately contact my primary care physician or go to an emergency room if a qualified representative of Coordinated Health Systems is not available.
4. _____ (Please initial). Prior to the imaging study, I read and answered the imaging questionnaires of Coordinated Health System, to the best of my ability. Further, I disclosed all of my allergies, previous surgeries, and current medications (prescription and over-the-counter) on said questionnaire. If I had any questions or uncertainty about the requested information, I noted it and understand that I must speak with a qualified representative of Coordinated Health Systems about it before the imaging study.
5. _____ (Please initial). The above procedure and its risks have been explained to my satisfaction. I agree that it may be presumed that all of my questions and requests for information were answered to my satisfaction if I undergo the above procedure, because I understand that I have the right to cancel the procedure at any time.
6. I have read this consent and its contents have been fully explained to me. I hereby certify that I understand the contents of the consent and that I am signing it voluntarily.

Signature of Patient or Legal Guardian/Relationship

Date

Witness
I have provided the patient and/or family with the information concerning the possible risks, complications and alternative methods of treatment

Arthrogram / IV Contrast Questionnaire

Name: _____

Study Ordered: **MRI Arthrogram** **CT Arthrogram** **Contrast MRI** **Contrast CT**
(Please circle one)

Family Physician: _____ Phone: _____

Cardiologist: _____ Phone: _____

Please answer the following questions as completely as you can:

- | | | |
|--|-----|----|
| 1. Are you over the age of 60? | Yes | No |
| 2. Are you diabetic? | Yes | No |
| If yes, are you taking Metformin/Glucophage/Glucoavance/Avandamet/Metaglib? | Yes | No |
| 3. Do you have anemia or any disease (s) that affects your blood, a history of renal disease, or seizures? | Yes | No |
| If yes, please describe: _____ | | |
| 4. Do you have any history of kidney problems or kidney transplant? (This includes kidney stones or infections.) | Yes | No |
| If yes, are you on dialysis? | Yes | No |
| 5. Do you have any history of liver problems or liver transplant? | Yes | No |
| 6. Are you currently or have you recently been treated with antibiotics? | Yes | No |
| If yes, date of last dose: _____ | | |
| 7. Do you have any allergies including latex, tape, seafood, shellfish or Iodine ? | Yes | No |
| If yes, please include symptoms and treatment: _____ | | |
| 8. Do you have any medication allergies? | Yes | No |
| If yes, please list: _____ | | |
| 9. Do you have any history of heart disease? | Yes | No |
| 10. Do you have any history of asthma? | Yes | No |
| 11. Do you have any history of sickle cell anemia? | Yes | No |
| 12. Have you had any recent barium studies? If yes, date: _____ | Yes | No |
| 13. Have you had any previous dye studies? | Yes | No |
| 14. Have you ever had a reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? (e.g. asthmatic, allergic, or respiratory reaction)? | Yes | No |
| If yes, please describe: _____ | | |
| 15. Have you recently or are you currently taking any blood thinning medications (e.g. Aspirin, Plavix, Coumadin)? | Yes | No |
| 16. Please list all medications that you are currently taking (over the counter or prescription): | | |

Within the past year have you experienced any of these symptoms:

- | | | | |
|--------------------------------------|-----|----|-------|
| Chest pain or angina | Yes | No | _____ |
| Irregular heartbeats or palpitations | Yes | No | _____ |
| Wheezing or chronic cough | Yes | No | _____ |
| Shortness of breath while lying flat | Yes | No | _____ |
| Excessive tiredness | Yes | No | _____ |

Do you have a history of:

Comments:

Heart disease	Yes	No	_____
High blood pressure	Yes	No	_____
Trouble clotting/ excessive bleeding	Yes	No	_____
Sleep apnea (snoring)	Yes	No	_____
Hiatal hernia, ulcers, reflux	Yes	No	_____
Hepatitis or HIV (AIDS)	Yes	No	_____
Thyroid or adrenal condition	Yes	No	_____
Stroke, TIA, or seizures	Yes	No	_____
Smoking	Yes	No	_____
Other Diseases	Yes	No	_____
Cancer	Yes	No	_____

If yes, when, type, treatment: _____

Special Needs of the Patient: _____
(Cultural, Physical, Religious, Medical, Emotional, Communication Barrier)

Due to the potential risk for **Nephrogenic Systemic Fibrosis (NSF)**, which may result in fatal or debilitating systemic fibrosis, those patients that answered yes to questions 1, 2, 3, 4 or 5 will need to obtain blood work (Serum Creatinine/Glomerular filtration rate (eGFR)) **PRIOR** to their contrast study. If you have any questions please ask our staff.

If blood work is needed: Lab Location: _____ Date: _____

FOR CONTRAST CT STUDIES- If you are diabetic and taking a medication that contains **Metformin**, it should be discontinued **PRIOR** to your examination. It should not be taken for 48 hours **AFTER** your examination. At that time, your kidney function should be re-evaluated by your physician, and you should not start taking Metformin again until kidney function has been found to be normal. Please refer to the patient information pages supplied to you with the medicine by your pharmacy. In the USA, **Metformin** is sold as a generic drug and is also present within drugs named **Glucophage, Glucovance, Avandamet, and Metaglip.**

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. I understand that the health care providers who will be performing and/or supervising my MR procedure are relying upon the statements contained in this form in determining whether to undertake the MR procedure and/or to attempt to secure other relevant information before undertaking the MR procedure.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Relationship: _____

Scheduler Initials: _____

Technologist Use Only

Contrast clearance: Verified Not Cleared

IV site/gauge: _____ Number of attempts: _____ Time given: _____

Contrast name/ml: _____

Comments/Reaction: _____

Lower Extremity MRI Questionnaire

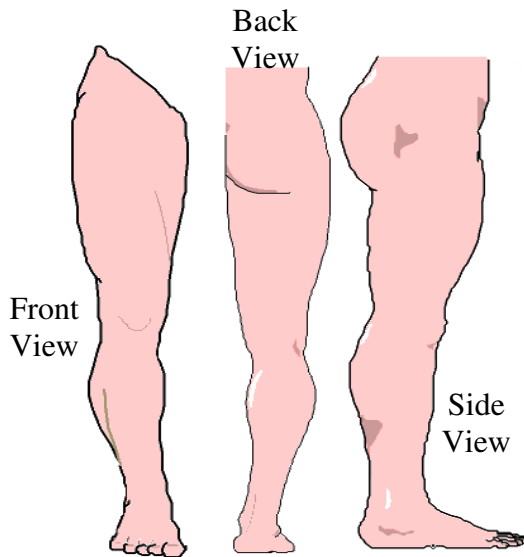
Patient Name: _____

1. What is your chief complaint for visiting us today? _____
2. Was this the result of an accident or injury? Yes No
 If yes, when was your accident or injury? _____
 Please describe what happened: _____

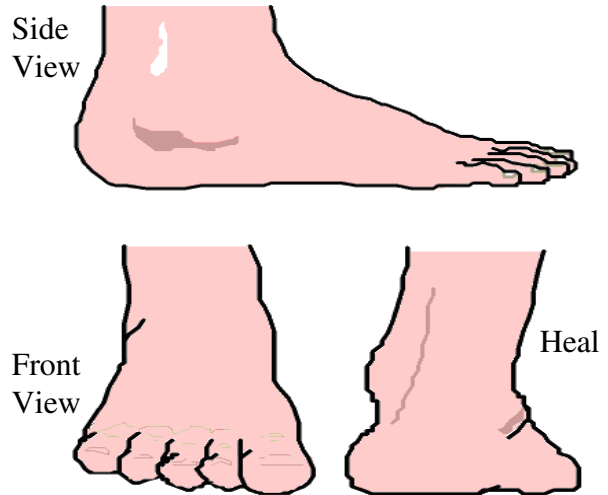
3. If there was no injury, are the symptoms related to overworking the joint as a result of your job, sport or hobby? Yes No
 If yes, what specific motion does your activity require? _____
4. Do your symptoms involve a certain area of the joint? Yes No
 If yes, where? (inside, outside, front, back) _____
5. If you answered no to questions 3 and 4, what other known conditions do you think could account for your symptoms? (e.g. arthritis, cancer) _____

Please indicate the location of your pain on the diagram below.

KNEE/HIP



FOOT/ANKLE



Patient/Guardian Signature: _____ Date: _____

Staff Use Only:

Implants/Metal fragments:	Clearance Verified	Not Cleared
Previous surgeries:	Clearance Verified	Not Cleared

History / why patient is being scanned: _____

Previous studies to body part: _____

Recent injections or aspirations: _____

Previous surgeries to body part: _____

Confirm body part and side: _____ Tech Initials: _____ Revised: 8/17/10

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Heart valve prosthesis
- 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 infusion pump
- Yes No Drug infusion device
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Artificial or prosthetic limb
- Yes No Other type of prosthesis (eye, penile, etc.)
- Yes No Eyelid spring or wire
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Other implanted ports
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g. breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures, dental implants or partial plates
- Yes No Metallic fragment / shrapnel / bullet / BB
- Yes No Tattoo / permanent makeup DATE: _____
- Yes No Body piercing jewelry
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia
- Yes No Do you have a history of cancer?
If yes, what kind, when, and reason: _____
- Yes No Have you had radiation or chemotherapy?
If yes, what kind, when, and reason: _____
- Yes No Radiation seeds or implants

FRIENDLY REMINDERS

- You must remove all jewelry (except wedding ring), hearing aid(s), infusion pumps and metallic items prior to your examination.
- Please leave all valuables at home.
- Please arrive 10 minutes prior to your appointment.
- Our facilities are not designed for small children. Please arrange for your children to have outside supervision while you are having your study.

Additional Comments:

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. I understand that the health care providers who will be performing and/or supervising my MR procedure are relying upon the statements contained in this form in determining whether to undertake the MR procedure and/or to attempt to secure other relevant information before undertaking the MR procedure.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Relationship: _____

Scheduler Initials: _____



Consent to Release Confidential Patient Information to Coordinated Health

I, _____ (patient name), give my permission to _____ (name of organization) to release information from my medical record(s) to _____ (person) at Coordinated Health for the purpose of patient care.

Please send:

- _____ All records from _____ to _____ (dates)
_____ Radiographs
_____ Laboratory
_____ Physical therapy
_____ Operative reports
_____ Discharge summary
_____ Radiology reports
_____ Other (please specify) _____

Patient's Name

Date

Patient's Signature

Date of Birth

Street Address

Phone

City, State, Zip Code

Social Security Number

If the patient is a minor, mentally or physically disabled, or deceased, the legally responsible party should sign and date this consent.

Signature of Parent/Legal Guardian

Date of Signature

Relationship to Patient

Surgical Specialty Center • Orthopedic Center • Back and Neck Center • Minimally Invasive Spine Center • Hand and Wrist Center
• Foot and Ankle Center • Imaging Center • Rehabilitation Center • Plastic Surgery Center • Arthritis & Osteoporosis Center

Table with 5 columns: Location, Address, City, State, Zip, Phone, Fax. Rows include Allentown, Bethlehem, Easton, and Brodheadsville locations.