



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? _____



Upper Extremity MRI Questionnaire

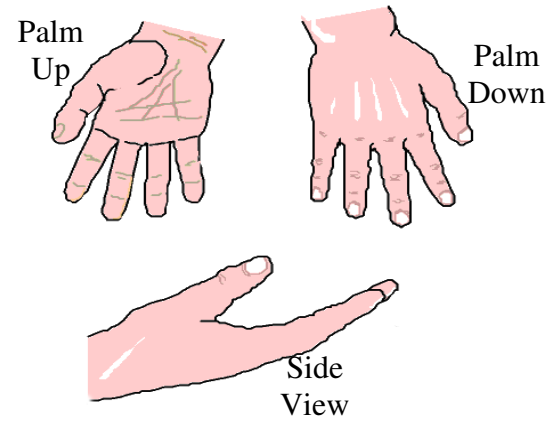
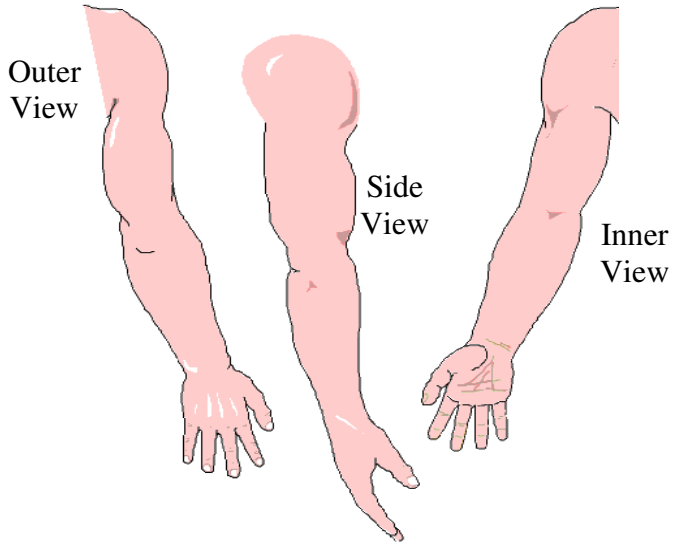
Patient Name: _____ Date: _____

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

SHOULDER/ELBOW

HAND/WRIST



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: _____

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, Phone, Fax. Includes locations like Allentown, Bethlehem, Easton, and Brodheadsville.