



Nombre: \_\_\_\_\_ Fecha de hoy: \_\_\_\_\_
Nombre Inicial Nombre adicional Apellido

Edad: \_\_\_\_\_ Altura: \_\_\_\_\_ Peso: \_\_\_\_\_

Por favor describa sus sintomas o problemas:

\_\_\_\_\_
\_\_\_\_\_

1. A tenido usted cirugia o operacion anterior (artroscopia, endoscopia, etc.) del alguna clase? [ ] Si [ ] No
Si, si, por favor indique la fecha y el tipo the sirugia:

Fecha: \_\_\_\_\_ Tipo de sirugia: \_\_\_\_\_
Fecha: \_\_\_\_\_ Tipo de sirugia: \_\_\_\_\_

2. As tenido un studio o examinacion de diagnostico anterior (MRI, CT, Ultrasonido, Radiografia, etc)? [ ] Si [ ] No

Table with 4 columns: Si si, por favor lista; Parte del Cuerpo; Fecha; Facilidad. Rows include MRI, CT/CAT Scan, Radiografia, Ultrasonido, Medicina Nuclear, Otro.

3. A estado usted diagnosticado con cancer? [ ] Si [ ] No
Si si, Tipo \_\_\_\_\_ Fecha del diagnostico: \_\_\_\_\_
Terapia de radiacion [ ] Si [ ] No Si si, Que tipo? \_\_\_\_\_

4. Por favor describa alguna condicion medica

\_\_\_\_\_
\_\_\_\_\_

5. As experimentado algun problema relacionado anterior con examinacion MRI o procedimiento MR? [ ] Si [ ] No

Si si, por favor describa: \_\_\_\_\_

6. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? [ ] Si [ ] No
As tenido una lecion al ojo envolviendo objeto o fragmento metalico (astillas metalicas, virutas, cuerpo extranjero, etc)?

Si si, por favor describa: \_\_\_\_\_

7. As tenido una lesion alguna ves por un objeto de cualquier clase (BB, bala, metralla, etc)? [ ] Si [ ] No
Si si, por favor describa: \_\_\_\_\_

8. Esta usted actualmente tomando o a recientemente tomado alguna droga? [ ] Si [ ] No
Si si, por favor lista: \_\_\_\_\_

9. Es usted alergico a alguna comida o medicina? [ ] Si [ ] No
Si si, por favor lista: \_\_\_\_\_

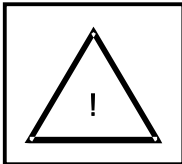
10. Su medico a prescrito algun sedante/medicacion especificamente para esta examinacion? [ ] Si [ ] No
Si si, por favor indique el tipo y la cantidad \_\_\_\_\_
Tiene conductor con usted hoy? [ ] Si [ ] No

Para paciented femeninas:

- 1. Fecha de ultimo periodo menstrual: \_\_\_\_\_ Poste menopausal? [ ] Si [ ] No
2. Esta usted embarazada o experimentando periodo menstrual? [ ] Si [ ] No

Comments:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

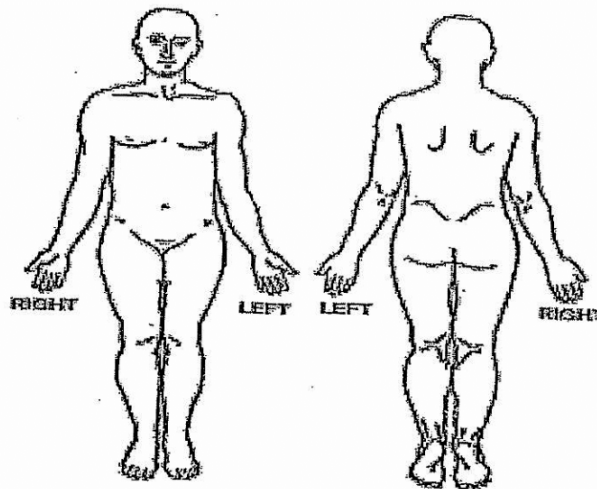


**ADVERTENCIA:** Ciertos implantes, mecanismo o objetos pueden ser peligroso para usted y/o puede interferer con el MR procedimiento (ex MRI, MR angiografía, MRI funcional, MR espectroscopico). **NO Entre** al cuarto de systema MR o ambiente de MR si usted tiene cualquier pregunta o asunto concendiente a implante, mecanismo, o objeto. Consulte el MRI Tecnologo o Radiologo ANTES de entrar al cuarto de systema de MR.  
**El systema MR magneto SIEMPRE esta puesto.**

**Por favor indique si tiene alguno de lo siguiente:**

- Si  No Clip Anuerismo
- Si  No Marcapasos cardiaco
- Si  No Defibrilador implantado del cardioverter (ICD)
- Si  No Implante o Dispositivo Electronico
- Si  No Implante o dispositivo magnetico-activado
- Si  No Systema Neurostimulados
- Si  No Stimulador de Espina Dorsal
- Si  No Electrodo Internales o alambres
- Si  No Crecimiento de hueso/stimulador de fusion de huesos
- Si  No Coclear, otologic o otro implante del oido
- Si  No Cualquier tipo de protesis (ojo, penile, etc.)
- Si  No Protesis de la valvula del corazon
- Si  No Resorte or alambre del parpado
- Si  No Miembro artificial o prostetico
- Si  No Stent metalicos, se filtran of arrollan
- Si  No Desviacion (espinal o intraventricular)
- Si  No Puerto y/o caterer vasculares del acceso
- Si  No Aemillas o implantes de la radiacion
- Si  No Swan-Ganz o caterer del thermodilutun
- Si  No Parcho de medicacion (nicotina, nitroglicerina, control de la natalidad)
- Si  No Cualquier fragmento metalico o cuerpo extranjero (bala, pelotillas, metralla)
- Si  No Cualquier implante del acoplamiento de alambre
- Si  No Ampliador del tejido fino (e.g., pecho)
- Si  No Grpas, clips o suturas quirurgicos metalico
- Si  No Reemplazo de las coyunturas (cadera, rodilla, etc.)
- Si  No Hueso/coyunturas, tornillo, clavo, alambre, placa, etc.
- Si  No IUD, diafragma, o pesario
- Si  No Dentaduras o placas parciales
- Si  No Tatuaje o maquillaje permanente
- Si  No Joyeria de la perforacion del cuerpo
- Si  No Ayuda de audencia para oir (Quite antes de entrar al cuarto de MR)
- Si  No Otro implante \_\_\_\_\_
- Si  No Problema Respiratorio o del movimiento
- Si  No Claustrophobia

**Por favor marca en la figura abajo la localizacion de cualquier implante o metal dentro de o en su cuerpo.**



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**IMPORTANT INSTRUCTIONS**

**Anter de entrar al ambiente del MR o sistema MR usted debe quitar todo objetos metalicos incluyendo protesis del oido, dentaduras, placas parciales, llaves, beeper, telefono celular, espejuelos, pinches del pelo, joyeria, joyas de porforacion del cuerpo, reloj, clips de ppel, pernos de seguridad, clip de dinero, tarjetas de credito, tarjetas de bacos, tarjetas de tira magnetica, monedas, plumas, cuchillo de bolsillo, corta unas, herramientas, ropa con sujetadores de metal, y ropa con hilos de rosca metalicos.**

**Por favor consulte el Tecnologo de MRI o Radiologo si tiene cualquier pregunta o preocupacion ANTES de entrar al cuarto de sistema MR.**

**NOTE:** Usted puede ser aconsejado o ser requerido para usar los auriculars o la otra poteccion de oido durante el procedimiento MR para prevenir problemas o peligros posibles relacionado con ruidos acusticos. MRI es generalmente un procedimiento seguro. El personal medico cualificado estara presente durante el procedimiento entero. El FDA ha determinado que MRI no presenta ningun gran riesgo.

Atestigo que toda la informacion propocionada esta corecta al mayor de mi conocimiento. Yo leo y entiendo tl contenido de esta forma y he tenido la oportunidad de hacer preguntas con respecto a la informacion sobre esta forma y en relacion con el MR procedimiento que estoy a punto de experimentar.

Firma de persona completando la forma: \_\_\_\_\_ Fecha: \_\_\_\_\_

Forma Completada por:  Pacient  Relativo  Enfermera \_\_\_\_\_  
 Impresione Nombre Relacion al paciente

Forma repasada por: \_\_\_\_\_  
 Tecnologo MRI  Radiologo Firma  
 Impresione Nombre

## Patient's Bill of Rights and Responsibilities

Each patient receiving services in an ambulatory care facility shall have the following rights and responsibilities:

1. Each patient has the right to be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. Each patient has the right to be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. Each patient has the right to be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;
4. Each patient has the right to receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. Each patient has the right to participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
6. Each patient has the right to be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
7. Each patient has the right to voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;
8. Each patient has the right to be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or Patient Rights or others from injury. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;
9. Each patient has the right to confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the New Jersey State Department of Health

for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

10. Each patient has the right to be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
11. Each patient has the right to not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State and Federal laws and rules;
12. Each patient has the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient; and
13. Each patient has the right to not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility.
14. It is the responsibility of the Center to know and understand the patient's bill of rights and responsibilities.
15. Patient will receive a signed copy of the "Patients Bills of Rights and Responsibilities" and the original document will be maintained in Medical Records.
16. Since effective treatment depends in part on patient's history, the center expects the patient or the patient's family to provide information about past illnesses, hospitalizations, medications, and other pertinent matters.
17. The Center expects the patient will ask questions about directions or procedures they don't understand.
18. The Center expects the patient to be considerate of other patients and staff in regard to noise, non-smoking, and number of visitors in the patient areas. The patient is also expected to respect the property of the Center and of other persons.
19. To help the patient's physicians and the Center staff care for the patient, the patients are expected to follow instructions and medical orders and report unexpected changes in their condition to their physician and Center staff.
20. The patient assumes financial responsibility for all services either through their insurance or by paying at the time of service.
21. The patients are expected to follow all safety regulations that they are told or read about.
22. If the patient fails to follow their healthcare provider's instructions, or if the patient refuses care, they are responsible for their own actions.
23. Except for emergencies, the technician shall obtain the necessary informed, written consent prior to the start of specified non-emergency procedures or treatments only after the procedure has been explained - in terms that the patient understands - specific details about the recommended procedure or treatment, the risks involved, the possible duration of incapacitation, and any reasonable medical alternatives for care and treatment. (N.J.A.C. 8:43G-4.1(a)7.) Informed consent is required by the State of New Jersey. (N.J.A.C. 8:43A-13.3(a)16.)
24. A patient or, if the patient is unable to give informed consent, a responsible person, has the right to be advised when a practitioner is considering the patient as a part of a medical care research program or donor program, and the patient, or responsible person, shall give informed consent prior to actual participation in the program. A

patient, or responsible person, may refuse to continue in a program to which he has previously given consent.

- 25. The patient who does not speak English shall have access, where possible, to an interpreter.
- 26. The patient can choose to change primary or specialty physicians or dentists if other qualified physicians or dentists are available.

The physicians, technologists and the entire staff at TOG MRI Center are committed to assure you reasonable care. Should you have a complaint or grievance related to TOG MRI Center., contact the Administrator at (609) 570--2211.

If your complaint or grievance is not resolved to your satisfaction, you may contact:

Division of Health Facilities  
Evaluation and Licensing  
New Jersey State Department of Health  
PO Box 367  
Trenton, New Jersey 08625-0367  
Telephone: (609) 792-9770

State of New Jersey  
Office of the Ombudsman for the  
Institutionalized Elderly  
PO Box 808  
Trenton, New Jersey 08625-0808  
Telephone: (609) 624-4262

Presentation of a complaint will not compromise your care under any circumstances.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date