



TOG MRI Center - Scheduler's MRI Screening Information Sheet

Date: _____

- Yes No Cardiac pacemaker Implanted cardioverter defibrillator (ICD)
- Yes No Brain aneurysm clip(s) or heart valve
- Yes No Electronic implant or device
- Yes No Short Leg Cast
- Yes No Wheelchair or Stretcher Bound

If responded **YES** to the above **STOP** and advise receptionist. If responded **NO** please complete form

Patient Name:

_____ (First) (Last)

Height: _____ Weight: _____

Date of Birth: _____ Phone #: _____

Trenton Orthopaedic Group – Completion Box

TOG Chart #: _____

Referring Dr.: _____

Next Orthopaedic Appointment: _____

MRI Appointment Date: _____

Body Part: _____

Prescription attached Facility: _____

Insurance _____

PreCert# _____

Date Issued _____ **Expiration** _____

Please indicate if you have any of the following:

- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Cochlear implant or implanted hearing aid
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis or implant
- Yes No Artificial or prosthetic limb
- Yes No Any metallic fragment or foreign body
- Yes No Any external metallic object
- Yes No Any coil, filter, stent or wire in a blood vessel (cannot be scheduled within 6 weeks of insertion)
- Yes No Other implant _____
- Yes No Have you had any type of injection in the area of the study? *If yes, wait 24 Hours*
- Yes No Are you Claustrophobic?

1. Do you have a history of kidney / renal failure? Yes No

2. Have you had prior surgery or an operation involving the heart, eye or brain or specifically to the area being scanned? Yes No
If yes, please indicate date and type of surgery: Date _____ Type of surgery _____

3. Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)? Yes No
If yes, please describe: _____

→ If YES, the patient needs orbit x-rays at least 24 hours in advance of MRI appointment

4. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? Yes No
If yes, please describe: _____

5. Have you ever been diagnosed with cancer? Yes No
If YES, Type _____ Date Diagnosed: _____
Radiation Therapy Yes No If yes, what type? _____

6. Are you pregnant or suspect that your are pregnant? Date of LMP/BC _____ Yes No

REMINDERS: Have patient bring previous MRI studies of same body part. The need for previous x-rays, ultrasounds and CT's will be determined by technologist. Patients under 18 years of age must be accompanied by an adult or legal guardian.

Pre-medicated? If yes, it will be necessary to have a licensed driver to drive patient from the exam.

TOG MRI Center Use Only

Scheduler's COMMENTS: _____