

PAUL A. COOK, M.D.
CHARAN GOWDA, M.D.
RAYMOND J. KOBUS, M.D.

THOMAS J. KOVACK, D.O.
LAWRENCE M. LUBBERS, M.D.
CHRIS M. MCCARTHY, M.D.
JAMES F. NAPPI, M.D.

Lower Extremity MRI Screening Questionnaire

Patient Name: _____	Date: _____
Patient Phone: _____	Exam: _____
Ordering Physician: _____	HMA #: _____
Height: _____	Weight: _____

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. Have you had any steroid injections in the joint of interest? Yes No
If yes, when was the injection? _____

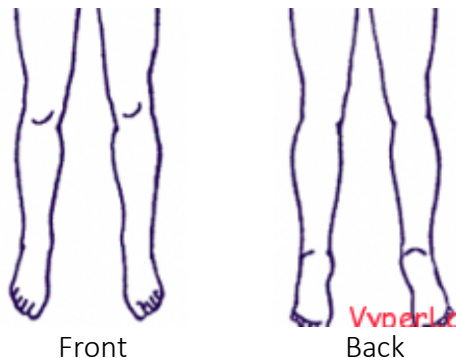
6. If you answered "no" to questions 3 and 4, what other known conditions do you think could account for your symptoms? (e.g. arthritis, cancer) _____

7. Any prior surgery on the area having the MRI?? Yes No
If so, what type of surgery and when? _____

Please indicate the location of your pain on the diagram below

Knee

Foot / Ankle



Please indicate if you have any of the following:

- Yes No Are you pregnant or trying to be pregnant
- Yes No Aneurysm clip(s)/surgical clips, staples
- Yes No Heart valve prosthesis
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Any electronic implant or device
- Yes No Neurostimulator
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Hearing aids or cochlear implant
- Yes No Insulin infusion pump
- Yes No Drug infusion device
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Artificial/prosthetic limb/other prosthesis
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Any implanted ports
- Yes No Metallic fragment / shrapnel / bullet / BB
- Yes No Body piercing jewelry/tattoos
- Yes No Any known allergies. If YES, please indicate:

FRIENDLY REMINDERS

You must remove all jewelry, hearing aid(s), infusion pumps, and metallic items **prior to your examination.**

- o Please leave all valuables at home.
- o Please arrive 15 minutes prior to your appointment.
- o Our facilities are not designed for small children. Please arrange for your children to have outside supervision while you are having your study.

******* Please be advised if you have any implanted mechanical devices we MUST have the serial number and model number. You should have been given a card with this information to determine if the MRI is safe for you to have *******

Please read the following pre-exam instructions:

REMOVE ALL JEWELRY, COINS, WATCHES, KEYS, PURSES/WALLETS, CREDIT CARDS, ID CARDS, OR ANYTHING MAGNETIC OR METALLIC FROM YOUR PERSON. THESE THINGS CAN BE AFFECTED BY THE MAGNETIC FIELD (EXPECIALLY CREDIT CARDS AND WATCHES). THEY CAN ALSO CAUSE THE EXAM IMAGES TO BE OF POOR QUALITY.

I have read and understand the above paragraph: _____ (initial here)

Your physician has ordered an MRI to evaluate your condition. Your exam should take about an hour. The results will be back to your physician in approximately three days. There should be no adverse affects after the exam.

Please schedule a follow-up appointment with your Hand and Microsurgery Associates physician for at least three days after your MRI exam has been completed.

I am signing this document giving consent to perform the MRI. If you have questions about the MRI exam, please ask the technologist.

Patient signature: _____ Account Number: _____

Technologist signature: _____ Pre-Cert: _____

Date: _____