**Lower Extremity MRI Screening Questionnaire**

<table>
<thead>
<tr>
<th>Patient Name: ______________________________</th>
<th>Date: ____________________</th>
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<tbody>
<tr>
<td>Patient Phone: ____________________________</td>
<td>Exam: ____________________</td>
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<tr>
<td>Ordering Physician: ________________________</td>
<td>HMA #: ____________________</td>
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<tr>
<td>Height: ___________________________</td>
<td>Weight: ____________________</td>
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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
- Front
- Back
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:

***** 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 (EXCEPT 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: ____________________________

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

- Please leave all valuables at home.
- Please arrive 15 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.