# MRI Screening Questionnaire

<table>
<thead>
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<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Patient Name:</td>
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<td>Date:</td>
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<td>Patient Phone:</td>
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<td>Ordering Physician:</td>
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<td>Patient DOB:</td>
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<td>Age:</td>
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<td>HMA #:</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? ________________________________________

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Please indicate the location of your pain on the diagram below

- [Shoulder / Elbow](#)
- [Hand / Wrist](#)
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 (ESPECIALLY 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: ____________________________ Date: ____________

Technologist signature: ________________________ Date: ____________

Auth on file:  YES  NO