Hand and Microsurgery Associates

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Upper Extremity MRI Screening Questionnaire

Patient Name: _____ Date: _____

Patient Phone: _____ Ordering Physician: _____

Patient DOB: _____ AGE: _____ Exam: _____

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) _____

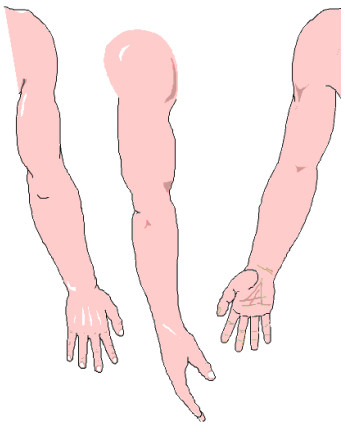
5. Have you had any steroid injections in the joint of interest? Yes No
If yes, when was the injection? _____

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) _____

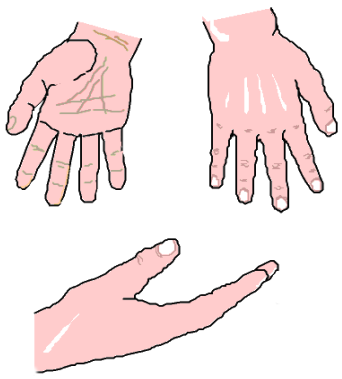
7. Any prior surgery on the area having the MRI?? Yes No
If so, what type of surgery and when? _____

Please indicate the location of your pain on the diagram below

Shoulder/ Elbow



Hand/ Wrist



See other side →

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 History of metal in your eyes
____ 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.**

- 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.

**** 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 ****

****Women between the ages of 11 and 55 will have to fill out a separate form for pregnancy screening and consent before the MRI can be performed. ****

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**