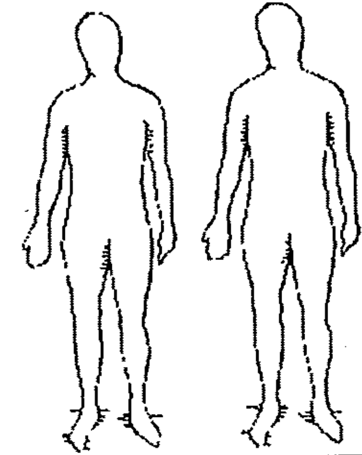
NAME ______________________________ AGE ________ WEIGHT ________

MRI SAFETY /SCREENING FORM

Location of Pain: Please mark area of pain



Female patients: Is there any possibility of pregnancy? Yes__ No __

Are you breast-feeding? YES__ NO__

Do you think you may be claustrophobic? Yes__ NO__

MRI is simple, safe, and painless. However, because we use strong magnets during the procedure, metal objects in your body may be hazardous or cause interference. Please provide us with this **IMPORTANT** information before entering the MRI department.

Do you have any of the following items in your body:

Pacemaker	YES_____	NO_____
Implanted electrical device	YES_____	NO_____
Ear / Cochlear implant	YES_____	NO_____
Neurostimulators	YES_____	NO_____
Brain / aneurysm clips	YES_____	NO_____
Stents	YES_____	NO_____
Metal in eyes	YES_____	NO_____
Tissue expander	YES_____	NO_____
Metal fragments or shrapnel	YES_____	NO_____
Magnetic dental implants	YES_____	NO_____

Any other metal objects or implants ____________________

If known, please give name and date of implant. ____________________

TECHNOLOGIST SECTION ONLY

Have you ever had an MRI? YES_____ NO_____ Have you ever had an injection of contrast for an MRI? YES_____ NO_____

SYMPTOMS: ______________________________

CANCER: ______________________________

TRAUMA: ______________________________

SURGERY: ______________________________

Creatinine: __________ GFR: __________ Contrast: ________Magnevist ________Multihance Sedation: __________

I hereby give my consent to Imaging Specialists of Charleston to perform an MRI as ordered by my physician. Sometimes MRI requires an injection of contrast. MRI contrast (gadolinium) is administered through a small needle placed into a vein. During the administration of MRI contrast (gadolinium), you may experience the sensation of the contrast being injected, which is normal and expected. MRI contrast (gadolinium) is quite safe, however as with all medications, there is a slight risk of an allergic reaction. The physicians and staff in the MRI Department are trained to respond to any emergency situation that may develop. In addition, we use the safest MRI contrast, which our physicians believe is best for you.

I have read and understand the above information and my questions have been answered. I consent to the use of paramagnetic contrast.

Signature ______________________ Relationship to pt. ______________ Date _______

PATIENT INFORMATION	UPDATED INFORMATION
MRN#	
Name	
DOB	
Address	
City, State, Zip	
Social Security #	
Home Phone #	
Work/ Mobile Phone#	
Email Address	
Policy Holder	
Relationship	
Guarantor DOB	

SCHEDULED EXAM:

Ref. Physician ______________________________

Ref. Physician Phone ______________________________

<u>Additional Physicians:</u>

Physician / Phone # ____

I understand that I am responsible for my bill and any charges or charge balances not paid by my insurance. I understand that there will be a fee of $35.00 for any checks returned for insufficient funds. I authorize payment direct to my physician. I authorize use of all medical information to process this claim. I authorize the qualified medical personnel of this facility to perform this procedure.

______________________________ ______________________________

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE DATE

MEANINGFUL USE FORM

PATIENT NAME: DOB: MRN:

Meaningful Use Defined:

Meaningful use is using certified electronic health record (EHR) technology to:

- Improve quality, safety, efficiency, and reduce health disparities
- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Ultimately, it is hoped that the meaningful use compliance will result in:

- Better clinical outcomes
- Improved population health outcomes
- Increased transparency and efficiency
- Empowered individuals
- More robust research data on health systems

Meaningful use sets specific objectives that eligible professionals (EPs) and hospitals must achieve to qualify for Centers for Medicare & Medicaid Services (CMS) Incentive Programs.

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Preferred Language:** ____________________

Please indicate any Family Health History -

Mother____________________ **Father**____________________

Sister____________________ **Brother**____________________

Race: (Please check one)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Caucasian

☐ Pacific Islander or Native Hawaiian ☐ Other

Smoking Status: (Please check one)
☐ Current everyday ☐ Current some day smoker ☐ Former smoker ☐ Never smoker ☐ Unknown

Height: **Weight :** **Blood Pressure:** ____________

Please list any known allergies (Include reaction):

____

____

Please list your current medications :

____

____

PATIENT RIGHTS AND AUTHORIZATION

PATIENT NAME: **DOS:** **MRN:**

A. Patient Rights: Please check the appropriate box below:

☐ I have been informed of my patient rights.

☐ I have been offered a written copy of my patient rights

B. Authorization to Release Medical Information to Family Members/Friends:

I give permission to Imaging Specialists to release information regarding appointment dates/times and my protected health information, including but not limited to, insurance, address, phone number, healthcare information, and treatment to the following individuals:

Name: ____________________________ Relationship to Patient: ____________________

Name: ____________________________ Relationship to Patient: ____________________

PLEASE CHECK HERE IF YOU DO NOT WISH TO LIST ANYONE ☐

______________________________________ ____________________
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENATIVE DATE

____
PRINT NAME OF ABOVE SIGNATURE