MRI SAFETY / SCREENING FORM

Location of Pain: Please mark area of pain
Right  Left  Left  Right

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.

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

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

UPDATERD INFORMATION

SCHEDULED EXAM:

Ref. Physician

Ref. Physician Phone

Additional Physicians:

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 REPRESENTATIVE               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 REPRESENTATIVE 

DATE 

PRINT NAME OF ABOVE SIGNATURE