MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE

LOCAL FORM TITLE *(Optional)*

YES	NO	PLEASE ANSWER THE FOLLOWING QUESTIONS IN THE SPACE TO THE LEFT:
		Have you ever had a surgical procedure that pertains to this MRI?
		Have you ever been injured by a metallic foreign body? (i.e. bullet, BB, shrapnel, metal shavings, etc)
		Have you ever done any welding or grinding of metals?
		Do you have history of kidney disease, seizure, asthma or allergic respiratory disease?
		Do you have any drug allergies? If so, please list:
		Do you have any body piercings? If YES, where? And are they removable?
		Do you have any new tattoos or tattooed eyeliner? Date?
		Are you in pain right now? If YES, how would you rate it on a 1-10 scale?
		For female patients, are you pregnant or is there a possibility that you may be pregnant? Last menstrual period date?
		Are you breastfeeding?
		ARE YOU CLAUSTROPHBIC?
		Are you 60 years of age?
		Have you had any x-rays taken within the last 6 months pertaining to this exam?
		DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
		Any type of implant held in place by a magnet?
		Any type of surgical clips or staples?
		Any orthopedic items - pins, rods, screws or plates, etc?
		Halo vest, or electronic, mechanical or magnetic implant?
		Any type of internal electrode(s) including: pacer wires, cochlear implants or other?
		Any type of intravascular coil, filter or stent? (i.e. Gianturco coil, Palmaz stent, etc.)

if you answered YES to any of the above, please briefly explain: _____

_____

_____

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:					
	Renal disease		One kidney		Diabetes
	Lupus		Hypertension		Multiple Myeloma
	Recent Chemotherapy		Organ Transplant		Recent invasive procedure or vascular injury
	Cardiac Pacemaker		Implanted cardiac defibrillator		Heart valve prosthesis
	Intraventricular Shunt		Vascular access port		Swan-Ganz catheter
	Neurostimulator		Any type of Biostimulator		Aneurysm clip(s)
	Implanted insulin pump		Implanted drug infusion device		Pessary
	Hearing aid		Any type of hearing implant		Orbital or eye prosthesis
	Diaphragm		IUD		Penal prosthesis or implant
	Artificial Limb or Joint		Dentures		Medication patch on the skin

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

AGE HEIGHT WEIGHT

IMPORTANT: Gadolinium DTPA or contrast may be given to enhance the results of the procedure. The most frequent adverse reactions, although unlikely, include tenderness, bleeding at the injection site, nausea, headache or dizziness. Because many drugs are excreted through human milk, it is recommended that patients, who are breastfeeding, temporary discontinue nursing for 24-48 hours.

I CERTIFY THE ABOVE TO BE TRUE AND ACCURATE AND I UNDERSTAND THAT OMITTING OR FALSIFYING INFORMATION ON THIS FORM COULD RESULT IN SERIOUS BODILY INJURY TO MYSELF.

PATIENT, PARENT OR LEGAL GUARDIAN'S SIGNATURE DATE

I HAVE REVIEWED THIS FORM FOR COMPLETENESS AND ACCURACY AND WITNESSED THE PATIENT'S SIGNATURE ABOVE.

WITNESSING TECHNOLOGIST'S SIGNATURE DATE

RADIOLOGIST'S SIGNATURE DATE

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