Orthopaedic & Neurosurgery Specialists PC

6 GREENWICH OFFICE PARK 40 VALLEY DRIVE GREENWICH, CT 06831

PHONE (203) 869-1145 FAX (203) 983-5385

PATIENT NAME: _____ **REFERRING PHYSICIAN**: _____

DATE OF BIRTH: _____ **WEIGHT**: _____ **HEIGHT**: _____

OCCUPATION: _____ **PRESENT COMPLAINT**: _____

PLEASE REMOVE ALL METAL OBJECTS BEFORE MRI EXAM

Cell phone, keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clips, coins, pens, belt, pocket knife, metal buttons & clothing with metal.

For Head and Neck Scans, please remove **Metallic Dentures**.

For your safety, please answer the following questions accurately:

Y	N	**Are you pregnant or are you breast feeding? Explain** _____
Y	N	**Have you ever worked with metal? Explain** _____
Y	N	**Do you have any known metals in your body? Explain** _____
Y	N	**Have you ever had any of the following diagnostic tests: (If yes, please circle) MRI, CT Scan, Ultrasound, NUC Medicine. If yes, which facility?** _____
Y	N	**Have you had any prior surgeries? If yes, on which part of your body?** _____
Y	N	**Have you ever had heart surgery? Explain** _____
Y	N	**Have you ever had ear surgery? Explain** _____
Y	N	**Have you ever had eye surgery? Explain** _____
Y	N	**Have you ever had Cancer? If yes, what part of your body?** _____
Y	N	**Do you have any Renal Disease? Explain** _____
Y	N	**Do you have any Liver Disease? Explain** _____
Y	N	**Have you had a Recent Colonoscopy / Endoscopy? ____ If yes, when?** _____
Y	N	**Do you have any known allergies? ____ If yes, to what?** _____

The following items may be hazardous to your safety and some may interfere with the MRI examination. Please answer "yes" or "no" for every item.

Heart Pacemaker	Y	N
Artificial Heart Valve or Stent	Y	N
Coronary Bypass	Y	N
Aneurysm Clip	Y	N
Nerve Stimulator	Y	N
I.V. Insulin Pump	Y	N
Medicated Skin Patches	Y	N
Cochlear Implant	Y	N

Hearing Aid	Y	N
IUD (Intrauterine device)	Y	N
Color Contact Lens	Y	N
Permanent Eyeliner or Tattoos	Y	N
Mesh Implants	Y	N
Body Piercings	Y	N
Joint Replacement	Y	N
Bone/Joint Pin, Screw, Wire, Plate	Y	N

PATIENT SIGNATURE: X_____ **DATE:** _____

IF UNDER 18, PARENT SIGNATURE: X_____ **DATE:** _____