MISSOULA Bone & Joint

MBJ MR Imaging
2360 Mullan Rd., Suite C
Missoula, MT 59808
Phone (406) 829-5567
Fax (406) 532-8774

MRI Patient History

Patient Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Ordering Provider: _____ **Date of Exam:** _____

Exam Type: _____ ☐ **Male** ☐ **Female** **ID#:** _____

When did the symptoms begin? _____

Is this a result of an injury? ☐ Yes ☐ No If yes, please explain injury? _____

Location of pain: _____

Dislocating, locking, catching, subluxing or giving out? _____

Swelling? ☐ Yes ☐ No If yes, where? _____

Popping or clicking? ☐ Yes ☐ No If yes, where? _____

Limited Range of motion? ☐ Yes ☐ No If yes, which motions? _____

Have you had surgery on this body part? ☐ Yes ☐ No If yes, when and where? _____ type? _____

Have you had any imaging of this body part? ☐ Yes ☐ No If yes, when, where and type? _____

Have you had x-rays of this body part? ☐ Yes ☐ No

If L/T Spine or Pelvis, are you currently being treated for cancer? ☐ Yes ☐ No If yes, what type, any chemo/radiation? _____

Do you have any cardiac implants? ☐ Yes ☐ No If yes, what? _____

Are you diabetic? ☐ Yes ☐ No If yes, do you wear an insulin pump or glucose monitor? _____

Order Details:

9/19/24 AM

MRI Metal Screening

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WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR system room or MR environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI Technologist or MRI Assistant BEFORE entering the MR system room.
The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- ☐ **Yes** ☐ **No** **Have you ever had a prior MRI at MBJ**
- ☐ **Yes** ☐ **No** **Cardiac pacemaker**
- ☐ **Yes** ☐ **No** **Pregnancy -** *Date of last period:* _____
- ☐ **Yes** ☐ **No** **Aneurysm clip(s)**
- ☐ Yes ☐ No Claustrophobia - *Pharmacy:* _____
- ☐ Yes ☐ No Metallic foreign body in eye currently
- ☐ Yes ☐ No Any shrapnel or metallic foreign body
- ☐ Yes ☐ No Metallic stent, filter or coil
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No Surgical staples, clips, metallic sutures or wire mesh
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Electronic implant or device, ICD, ICM
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Spinal cord stimulator or neuro stimulation system
- ☐ Yes ☐ No Bone growth/bone fusion stimulator
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, heart, etc.)
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Hearing aid (*Remove before entering MR Room)*
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No IUD, diaphragm or pessary
- ☐ Yes ☐ No Tissue expander (breast or skin)
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
- ☐ Yes ☐ No Body piercing jewelry (*Remove)*
- ☐ Yes ☐ No Tattoo, permanent makeup or magnetic lashes
- ☐ Yes ☐ No Dentures or partial plates

IV CONTRAST

If the patient answered "Yes" to any of the above questions, a blood draw to test for Creatinine/GFR will be ordered:

- ☐ Yes ☐ No Severe allergic reaction to Gadolinium
- ☐ Yes ☐ No History of Renal Disease
- ☐ Yes ☐ No Dialysis of any type
- ☐ Yes ☐ No Kidney transplant
- ☐ Yes ☐ No Severe hepatic disease or other liver issues
- ☐ Yes ☐ No Kidney cancer
- ☐ Yes ☐ No Prior kidney surgery or only one kidney
- ☐ Yes ☐ o History of Diabetes
- ☐ Yes ☐ No Recent history of chemotherapy in the past 3 months
- ☐ Yes ☐ No Pregnancy

If the patient has answered yes to pregnancy or any known contrast allergy, the scheduler should route the order back to the referring provider for their discretion on how to proceed with the contrast exam.

NOTES / PENDING CLEARANCE

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on the form and regarding the MR procedure that I am about to undergo. I have also been informed of other facilities to receive MRI services.

Patient / Guardian Signature: _____ **Date:** _____

Form Information Reviewed By: _____ Date: _____