Radiology Center of Fair Lawn
Patient Information Form – MRI

Patient Chart #: _____ Date: _____

[ ] Male [ ] Female

Patient Name: _____ Date of Birth: ____/____/_____ SS#: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone #'s: (Home) _____ (Work) _____ (Cell) _____

Referring Physician: _____ Phone #: _____ /Fax#: _____
Additional Physician: _____ Phone #: _____ /Fax#: _____

Primary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the primary insurance carrier? YES NO
If **NO**, please fill out the following information:
Name of Primary Insurance carrier: _____ Relationship to Patient: _____
Date of Birth: ____/____/_____ Primary Insurers SS#: _____ Phone #: _____

Secondary Insurance Information
Insurance Company Name: _____
Insurance Group #: _____ Insurance ID#: _____
Are you the secondary insurance carrier? YES NO
If **NO**, please fill out the following information:
Name of Secondary Insurance carrier: _____ Relationship to Patient: _____
Secondary Insurers Date of Birth: ____/____/_____ Secondary Insurers SS#: _____ Phone #: _____

In the event of an emergency, please contact:
Name: _____ Relationship: _____ Phone #: _____

Why is your referring physician requesting that you have this exam? _____
Is there any possibility of pregnancy? YES NO
Do you have a pacemaker? YES NO ***(If, YES – STOP! This patient cannot have an MRI)***
Do you have aneurysm clips? YES NO
Have you had any previous surgery to the location in which we will be scanning? YES NO
If YES, please list the type of surgery and the procedure date: _____
Do you have medical implants of ANY type? YES NO
What type of implants? _____
Have you ever been diagnosed with cancer? YES NO
If YES, please list the type and form of treatment: _____
Do you or have you had **any** incidental or prolonged exposure to metal or the metal industries due to employment, an accident or for any other reason? YES NO
If answered YES, please explain: _____
Have you had an orbital x-ray for MRI clearance? YES NO
Have you had any relevant x-rays or other testing done prior to today's exam? YES NO
If YES, when and where were the prior tests performed and what were the results? _____
Do you have asthma? YES NO
Do you have any kidney disease or dysfunction? YES NO
Do you have diabetes? YES NO
If YES, what diabetes medications are you currently taking? _____
Which doctor manages your diabetes? _____ Phone #: _____

I attest that the above information is correct and true to the best of my knowledge. I have read and understood the entire contents of this form and have had the opportunity to ask questions regarding its requested information.

Signature (Patient or Legal Guardian): _____ Date: _____

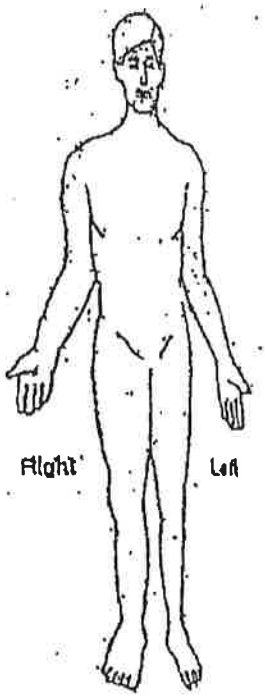
height: _____ Weight: _____

THE FOLLOWING ITEMS MAY BE HAZARDOUS OR MAY INTERFERE WITH THE MRI EXAMINATION BY PRODUCING AN ARTIFACT

PLEASE INDICATE IF YOU ANY OF THE FOLLOWING:

YES	NO	
___	___	Cardiac Pacemaker
___	___	Aneurysm Clip(s)
___	___	Implanted cardiac defibrillator
___	___	Neurostimulator
___	___	Any type of biostimulator
		Type:_____
___	___	Any type of internal electrode(s), including:
		Pacing wires
		Cochlear implant
		Other:_____
___	___	Implanted Insulin pump
___	___	Swan-Ganz catheter
___	___	Halo vest or metallic cervical fixation devices
___	___	Any type of electronic, mechanical, or magnetic implant
		Type:_____
___	___	Hearing Aid
___	___	Any type of intravascular coil, filter, or stent
		(e.g., Gianturco coil, Gunther IVC filter, Palmaz stent, etc.)
___	___	Implanted drug infusion device
___	___	Any type of foreign body, shrapnel, or bullet
___	___	Heart valve prosthesis
___	___	Any type of ear implant
___	___	Penile Prosthesis
___	___	Orbital/eye Prosthesis
___	___	Any type of implant held in place by a magnet
___	___	Any type of surgical clip or staple(s)
___	___	Vascular access port
___	___	Intraventricular shunt
___	___	Artificial limb or joint
___	___	Dentures
___	___	Diaphragm
___	___	IUD
___	___	Pessary
___	___	Wire mesh
___	___	Any implanted orthopedic item(s) (e.g., pins, rods, screws, nails, clips, plates, wire, etc.)
		Type:_____
___	___	Any other implanted item
		Type:_____
___	___	Tattooed eyeliner*

Please mark on the drawing the location of any metal inside your body.



*A small percentage of patients with tattooed eyeliner have experienced transient skin irritation in association with MRI. Therefore, you must decide if this slight risk warrants undergoing your examination. You may want to discuss this matter with your referring physician.

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient's Signature_____

RT Signature_____ Date_____

RT Name_____