Metal Implants, Devices, Pumps, Etc.



Imaging by Specialists

2202 WILSHIRE BLVD., SANTA MONICA, CA 90403 • TEL: 310-264-9000 • FAX: 310-264-9004 • www.TowerSJI.com

MRI EXAM Date _____ / _____ / _____ Patient ID#: Name: _____ Sex: _____ Age:____ Physician: Date of Birth: _____ / _____ / ______ Height: _____ Weight: _____ Procedure: ____ Diagnosis: Reason for Exam: Have you had a previous MRI? () Yes () No If yes, what body part? _____ The following items may interfere with MRI imaging, and some could be hazardous to your safety. Please check the following: Cardiac Pacemaker) No () Yes Cochlear Implants () No () Yes () Yes **Brain Surgery** () No Seizures () No () Yes Neurostimulator (TENS unit) () Yes) No Insulin Pump () No () Yes Hearing Aid () Yes () No IUD () No () Yes Females: Is there a possibility you may be pregnant? () No () Yes () Yes Fractured Bones, treated w/metal rods, screws () No Spinal Rods () No () Yes Prosthesis () Yes) No Wire Suture () No () Yes Shrapnel, Bullets () No () Yes Removable Dentures () No () Yes Any Metal Fragments () No () Yes Have you ever worked w/ grinding metal) No () Yes Other metal implants () No () Yes Penile Prosthesis () No () Yes Orbital/Eye Prosthesis () No () Yes Artificial Limb or Joint () No () Yes **Dental Retainer** () Yes () No

) No

) Yes

Continued...



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Auestions Related to Your MRI Exam: (Please check all that apply) Brain Surgery () No () Yes adiation Therapy () No () Yes hadiation Therapy () No () Yes history of Cancer () No () Yes headaches () No () Yes hearded check () No () Yes hearded () No () Ye	For female patients:	Please indicate location of pa		
Questions Related to Your MRI Exam: (Please check all that apply) Strain Surgery (() No		•
Radiation Therapy Radiation Th	Are you breast recaing	()110	() 163	·
No	Questions Related to Your MRI Exam: (Please ch	neck all that apply)		FRONT
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distory of Cancer () No () Yes leadaches () No () Yes Selezures () No () Yes Memory Loss () No () Yes learing Problems () No () Yes Aranlysis () No () Yes Memory Loss ()	Radiation Therapy	() No	() Yes	
	Chemotherapy	() No	() Yes	
Seizures	History of Cancer	() No	() Yes	(
Memory Loss	Headaches	() No	() Yes	//\ (\\
Memory Loss	Seizures	() No	() Yes	
Hearing Problems	Memory Loss	` ,	` '	
Paralysis			` ,	7/ / / \ }
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MJ (Jaw) Problems (I) No (I) Yes Aleck Pain (I) No (I) Yes Joper Extremity Pain (I) No (I) Yes Joper Extremity Pain (I) No (I) Yes Joper Extremity Pain (I) No (I) Yes John (I) Yes BACK Aleck Burgery (I) No (I) Yes Weight Gain / Loss Jomiting (I) No (I) Yes Joannier (I) No (I) Yes Joa		` ,	` '	() ()
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Diarrhea Chest Pain Ch	Weight Gain / Loss	() No	() Yes	
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Patient's Signature:	Abdominal Pain	() No	()Yes	
Patient's Signature:	Surgery on body part to be examined	() No	() Yes	
Popping of Joint () No () Yes () Yes () No () Yes () Yes () No () Yes (Pain	() No	() Yes	1// / /]
Clicking of Joint () No () Yes f you answered yes to any of the above questions, please explain: Other patient symptoms: Patient's Signature:	Popping of Joint	` ,	` '	*
Patient's Signature: Date: / /		` ,	` '	1/11
Patient's Signature: Date: / / /		ns, please explain: _	` '	
Patient's Signature: Date: / / /				
Patient's Signature: Date: / / /				
	Other patient symptoms:			
Technologist:	Patient's Signature:		Date:	11
	Technologist:			