MEDICAL ARTS RADIOLOGY

medartsrad.com

MRI SCREENING

REFERRAL FORM

Bay Shore · Patchogue · Commack · Plainview · Massapequa · West Islip · Huntington · East Setauket

Patient's Name______________________________ Date______________ Height________ Weight______

Referring Physician____

	No	Yes
Previous MR study?	___	___

If yes, date and type of study: ______________________________

	No	Yes
Previous surgeries?	___	___

If yes, date and type of surgery: ______________________________

____

	No	Yes
History of cancer?	___	___

If yes, when and specify ______________________________

	No	Yes
Have you ever worked in a machine shop or similar environment where you may have been subject to small metal slivers, particularly in the eyes?	___	___

The following items can interfere with MR Imaging and some can actually be hazardous to your safety. Please indicate if you have any of these items.

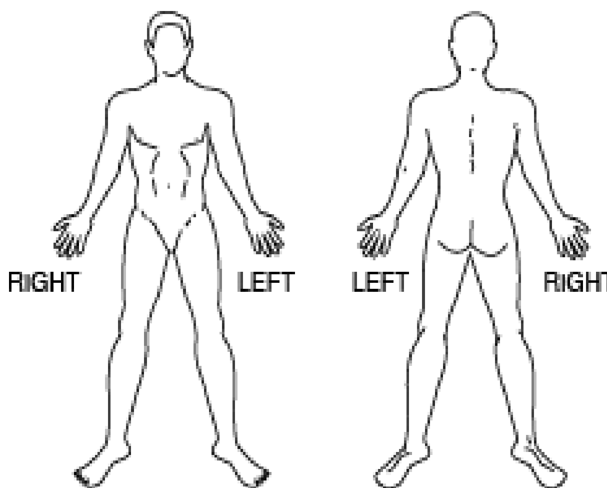
	No	Yes
Cardiac pacemaker or lead wires	___	___
Artificial heart valve	___	___
Aortic clips	___	___
Brain aneurysm clips	___	___
Neurostimulator or lead wires	___	___
Electronic implant or device	___	___
Insulin or other infusion pump	___	___
Electrodes or wires	___	___
Cochlear or other ear implant	___	___
Hearing aid	___	___
Metallic stent, filter or coil	___	___
Shunts	___	___
Joint replacements	___	___
Fractured bones treated with Metal rods, plates, pins, screws, or nails	___	___
Any type of prosthesis	___	___
Metal mesh implant	___	___
Surgical staples or wire sutures	___	___
Shrapnel	___	___
Dentures or partial plates	___	___
Metal slivers in the eyes	___	___
Tattoo or permanent make-up	___	___
Body piercing jewelry	___	___
Any metal fragments or foreign body	___	___

Other: Please specify______________________________

	No	Yes
Do you have a history of kidney disease?	___	___
Are you allergic to Latex?	___	___

Please indicate area of pain, mass, or symptom.

Also, please indicate location of any implant or metal inside or on your body.



If you received IV contrast for an MRI or CT in the past:

	No	Yes
Did you have any problems?	___	___

If yes, please explain: ______________________________

FEMALE PATIENTS ONLY:

	No	Yes
Are you pregnant?	___	___
Are you breast feeding?	___	___
Do you have an IUD?	___	___
Do you have breast tissue expanders?	___	___

Patient Signature:

____