Patient Name: DOB: DOE:

MRI Screening Form

It is important for us to know your medical history so our radiologist and staff can utilize certain scanning protocols to better diagnose your condition. If you have any question please ask us to explain.

Mobridge Regional Hospital and Clinics

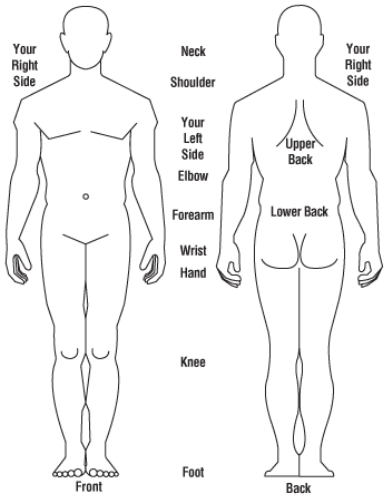
Do you have any of the following?

Yes	No	Pacemaker, Defibrillator, Cardiac Monitor or Leads	Yes	No	Nerve stimulator
Yes	No	Cochlear or Stapes (Inner Ear) Implants	Yes	No	Vascular Coil, Umbrella (filter for clots) or Stent
Yes	No	Brain Aneurysm Clip	Yes	No	Can you lie still for 30 minutes?
Yes	No	Neurostimulator/Spinal Cord Stimulator	Yes	No	Are you claustrophobic?

If yes to any of the above devices, please provide the model # of the implanted device. If you are not able to provide the appropriate information regarding the implanted device, the patient will NOT be scanned.

Model # _____

Please describe in your own words why your provider ordered an MRI exam today.
(What is the problem? Where is the problem?)



Yes No Do you have pain? If so, where & how long?

Yes No History of Diabetes
Yes No History of Stroke
Yes No History of MS
Yes No Do you have a personal history of cancer?
If yes, what type? _____

Yes No Any recent trauma or injury (date and area of injury)? _____
_____

Yes No Have you had any surgeries on the body part being imaged today?
If YES, please list _____

Yes No Are you currently pregnant or suspect that you are pregnant?

Patient Signature: _____ Date: _____