SHASTA ORTHOPAEDICS & SPORTS MEDICINE
CARE EXPERTISE TECHNOLOGY

ABOUT YOUR MRI

The MRI is a very strong magnet. For your safety before your procedure we must screen you for any metal in your body. To assist us in this screening process we ask that you answer the questions on the back of this sheet and return it to us. Some metal objects may harm you or may interfere with the quality of your procedure. Some examples of objects containing metal are:

- Pacemakers,
- defibrillators,
- brain aneurysm clips,
- bone/neuro stimulators,
- cochlear or stapes implants,
- Implanted insulin or infusion pumps
- carotid artery vasular clamp,
- heart valve prothesis,
- eye implants
- bullets, shrapnel,

If you have any of these items additional precautions prior to your MRI may be required. Also, if you have worked with metal, or have metal in your eye, an orbital x-ray may be required to clear you prior to your MRI.

Please be sure you have told us if you <u>think</u> you may have any metal in your body.

Because the MRI is a magnet we ask that you remove any jewelry, watches, piercings, pocketknives loose change and hair clips at home.

The Types of MRI procedures and our pre-procedure instructions are found below:

MRI

If you are scheduled for a standard MRI appointment, no special preparation is necessary. The only requirements for this procedure are that you have no metal in or on your person, and that you are not claustrophobic. If you do not know or if you are unsure please let the MRI technician or nurse know before your procedure begins.

MRI WITH CONTRAST

Please remember that your study is with contrast so do not have anything to eat or drink 4 hours prior to the study. This includes water, coffee and mints. It is necessary that you arrive thirty minutes before your scheduled appointment time.

MRI WITH SEDATION

If you are having an MRI with sedation, you are not required to fast, your arrival time is forty five minutes prior to your study, and you must be accompanied by a driver.

Please be prepared to pay any co-payment, deductible or co-insurance payments prior to the procedure. If you have any questions or concerns please do not hesitate to call us at (530) 246-2467.

Shasta Orthopaedics MRI Patient History and Screening

Patient Name: _____ Referring Doctor: _____ Date: ___/___/___

Height: _____ Weight: _____ Date of Birth: ___/___/___ Age: _____

Main Symptom (reason for your visit): _____

The MRI is a very strong magnet. Before you are permitted to enter we must know if you have any metal in your body. Some metal objects can interfere with your scan and be dangerous, please answer the following carefully.

Do you have any of the following? (Please Circle):

Pacemaker	**Yes**	**No**	**Hearing Aid/Wig**	**Yes**	**No**
Internal Defibrillator	**Yes**	**No**	**Artificial Limb/Joint**	**Yes**	**No**
Brain Aneurysm Clip	**Yes**	**No**	**Eye Implants**	**Yes**	**No**
Previously Worked with Metal	**Yes**	**No**	**Earrings/Hairpins/Body Piercings**	**Yes**	**No**
Piece of Metal in Eye	**Yes**	**No**	**Permanent Tattoo Make-up**	**Yes**	**No**
Neurostimulator (TENS unit)	**Yes**	**No**	**Magnetic Implants Anywhere**	**Yes**	**No**
Cochlear or Stapes Ear Implant	**Yes**	**No**	**Any Other Implants such as: Orthopaedic Pins/Rods/Screws/ Nails/Wires/Bullets/Shrapnel, etc.**	**Yes**	**No**
Implanted Insulin Pump	**Yes**	**No**	**If yes, where?_____**		
Implanted Drug Infusion Pump	**Yes**	**No**	**Dentures, Retainers, Braces or device held by MAGNET**	**Yes**	**No**
Carotid Artery Vascular Clamp	**Yes**	**No**			
Heart Valve Prosthesis	**Yes**	**No**			
Claustrophobic	**Yes**	**No**			

Please List Surgeries:

Type: _____ **Date:** _____

Type: _____ **Date:** _____

Type: _____ **Date:** _____

Please list previous studies of area being scanned today. Please give place and date.

CT _____ Date: _____ MRI _____ Date: _____ SONOGRAM _____ Date: _____

Do you have a history of Tumor, Cancer, or Lymphoma?____ If yes, what type?_____

Do you have a history of Kidney Disease or Renal Failure?_____

Please list your **allergies**: _____

Are you now or could you be **pregnant**? _____L.M.P. _____

PLEASE REMOVE ALL: WATCHES, WALLETS, JEWELRY, AND ALL LOOSE METAL FROM POCKETS

I attest that the above information is correct to the best of my knowledge.

Patient or Guardian Signature: _____ **Date:** _____

For Office Use Only

Contrast used _____ Volume _____ cc Sedation used _____ Volume _____ cc/mg

Technologist

Notes: _____

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