2405 ATHERHOLT ROAD
LYNCHBURG, VA 24501

MRI REQUEST

SCHEDULING - (434) 485-8521
FAX (434) 485-8599

MRI APPOINTMENT DATE: ___/____/___
TIME: _____________ **am** **pm**

PATIENT INFORMATION (PRINT)

Patient's Name ____ Date of Birth _____ /_____ /_______
First M.I. Last

Phone: (_______)______________________ Work: (_______)____________________ Cell: (_______)___________________

Diagnosis ____

Insurance Carrier ____ Referral/Authorization #: _____________________
(Attach Front & Back Copy of Insurance Card)

Referring Physician ____ Physician Office Contact _________________________

Phone (______) ______________________ Fax (______)__________________________

Patient's Weight ______________

Creatinine ________________ (copy of lab results to be faxed for contrasted studies)

TYPE OF MRI REQUESTED

☐ Pelvis
☐ Brain

☐ Hip - ☐R / ☐L
☐ Extremity
- ☐Ankle ☐R / ☐L
- ☐Elbow ☐R / ☐L
- ☐Foot ☐R / ☐L
- ☐Hand ☐R / ☐L
- ☐Knee ☐R / ☐L
- ☐Shoulder ☐R / ☐L
- ☐Wrist ☐R / ☐L
- ☐Other (Specify)____________________

☐Spine
- ☐C-Spine
- ☐T-Spine
- ☐L-Spine

REFERRING PHYSICIAN REQUEST

Send CD of MRI with Patient: ☐
or

Send CD of MRI to Ordering Physician ☐
Mail to:
____
____
____
____

Contrast ☐with ☐with/without

Intelemage™
Go to https://share.intelemage.com and click "**Signup now for a free account**" to have results and images sent to you electronically.
Contact us for more information at 434.485.8521.
Email: ____________________________

____

Physician's Signature (Required) **Date**

Health History Questionnaire for MRI

WARNING! If you have impaired kidney function, require kidney dialysis, or have a personal history of kidney disease, please notify a staff member IMMEDIATELY.

Patient Name____ Date of Birth ___/___/___

Examination Type ____ Examination Date ___/___/___

☐Yes ☐No Do you have any drug allergies? Please list:

____

____

☐Yes ☐No Are you or could you possibly be pregnant?

☐Yes ☐No Are you breast-feeding? Breast milk should be discarded for 48 hours after injection.

☐Yes ☐ No Have you ever had a previous allergic reaction to MRI contrast?

☐Yes ☐No Do you have severe allergies (not minor seasonal allergies)?

☐Yes ☐No Do you have asthma?

☐Yes ☐ No Do you have hemolytic anemia?

☐Yes ☐No Do you have sickle cell disease?

☐Yes ☐No Do you have a history of kidney disease? Kidney transplant?

☐Yes ☐No Do you have severe liver disease? Recent liver transplant or currently awaiting transplant?

☐Yes ☐No Do you have poorly controlled hypertension? (Greater than 180/110 mmHg)

☐Yes ☐No Do you have cardiomyopathy or congestive heart failure?

☐Yes ☐No Do you have diabetes? If yes please answer the following:

- ☐Yes ☐No Are you currently under the care of a physician for your diabetes?
- ☐Yes ☐ No Do you have retinopathy? (eye disease related to your diabetes)
- ☐Yes ☐No Do you have neuropathy? (Numbness, tingling, burning in extremities)

☐Yes ☐No Do you have heart disease?

☐Yes ☐No Do you have a history of stroke or TIA?

☐Yes ☐No Do you have any lower extremity problems? (cold feet or legs, infections, sores that won't heal)

☐Yes ☐ No Are you currently taking any medication containing metformin? These include Metformin (generic), Avandamet, Glucophage, Glucophage XR, Glucovance, Metaglip, Glumetza, Fortamet, Riomet, ACTOPLUS Met, and Janumet.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form, and have had the opportunity to ask questions regarding the information on this form and the procedure I am about to undergo.

Signature of Person Completing Form: _______________________________ **Date** _____/_____/_____

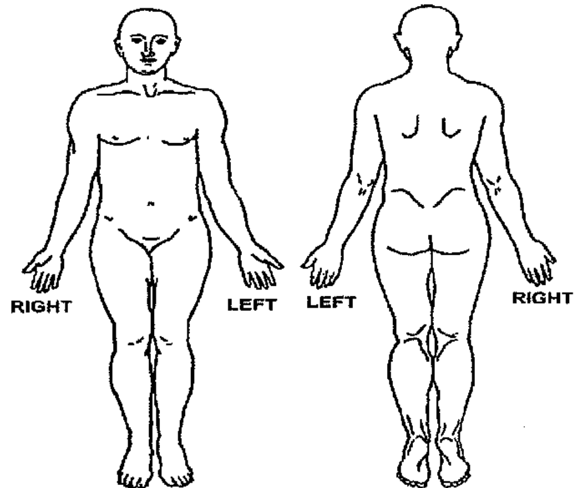
Signature of Technologist: ____ **Date** _____/_____/_____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulation system
- ☐ Yes ☐ No Spinal cord stimulator
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth/bone fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
- ☐ Yes ☐ No Heart valve prosthesis
- ☐ Yes ☐ No Eyelid spring or wire
- ☐ Yes ☐ No Artificial or prosthetic limb
- ☐ Yes ☐ No Metallic stent, filter, or coil
- ☐ Yes ☐ No Shunt (spinal or intraventricular)
- ☐ Yes ☐ No Vascular access port and/or catheter
- ☐ Yes ☐ No Radiation seeds or implants
- ☐ Yes ☐ No Swan-Ganz or thermodilution catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
- ☐ Yes ☐ No IUD, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid
  (Remove before entering MR system room)
- ☐ Yes ☐ No Other implant ____________________
- ☐ Yes ☐ No Breathing problem or motion disorder
- ☐ Yes ☐ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: ______________________________ Date _____/_____/_____
Signature

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse ______________________________ ______________________
Print name Relationship to patient

Form Information Reviewed By: ______________________________ ______________________________
Print name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other____________________