

The Imaging Center
 Main 970-282-2900 • Scheduling 970-282-2912 • Fax 970-282-9800
 at Harmony: 2127 E. Harmony Road • Fort Collins, CO • 80528
 at Centerra: 2500 Rocky Mountain Avenue, Ste. 150 • Loveland, CO • 80538

MRI SCREENING FORM
BEFORE SCHEDULING, PLEASE FILL OUT BOTH SIDES & FAX

Name _____
 Date of Birth _____
 Male or Female (check one)
 Weight _____
 Phone (H) _____ (W) _____

REFERRING PHYSICIAN'S OFFICE

Referring Physician _____
 Date of Exam _____
 Exam Requested _____

 Symptoms & ICD-9 Code _____

***The following are contraindications for having an MRI if answered YES.**

YES	NO	Removed	
_____	_____		*Cardiac Pacemaker or Lead Wires
_____	_____		*Aneurysm Clips (Brain Clips) (make & model) _____
_____	_____		*Breast Tissue Expanders (excluding implants)
_____	_____		Ocular Implant (eye)
_____	_____		Ear Implant (make & model) _____
_____	_____		Heart Valve(s) (make & model) _____
_____	_____		Neurostimulator (Tens Unit)
_____	_____	_____	Hearing Aids
_____	_____	_____	Dentures (Removable)
_____	_____		Infusion Pump
_____	_____		Pregnant
_____	_____		Nursing (Must express milk for 24 hours after injection of contrast.)
_____	_____		Other metal items removed and secured by patient.
			List: _____

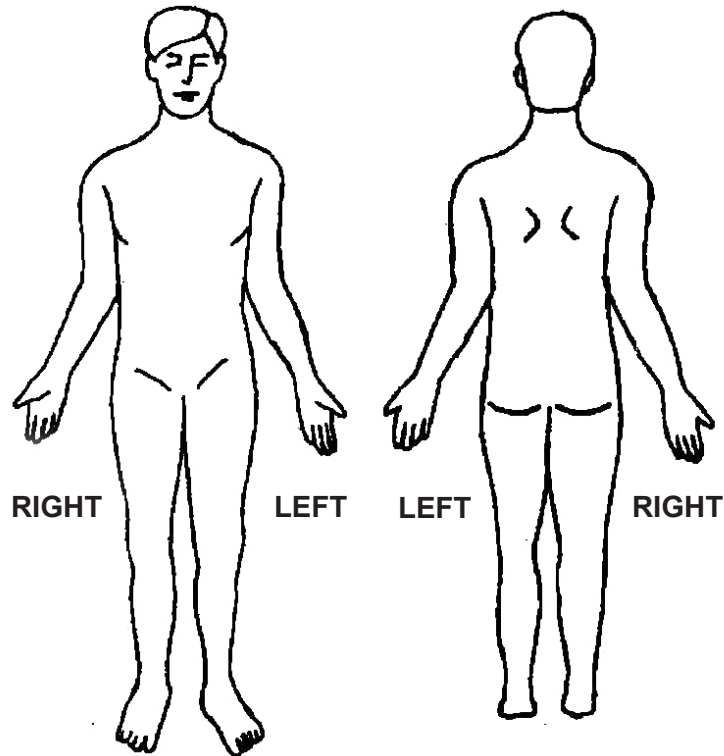
- | | YES | NO |
|---|-------|-------|
| • Have you ever been diagnosed with cancer?
If so, what kind? _____ | _____ | _____ |
| • Have you ever seen a Physician for metal in your eye(s)?.....
If "YES", call ahead for instructions. | _____ | _____ |
| • Do you have any kind of metal in your body? _____
If "YES", where _____ | _____ | _____ |
| • Are you claustrophobic or unable to lie still due to pain or anxiousness?.....
If "YES", please notify scheduling before your appointment. | _____ | _____ |
| • Any severe medication allergy or contrast media reaction? _____
Please list _____ | _____ | _____ |
| • Previous MRI exams (Dates/Location) _____ | | |

Please describe your chief complaint/reason you saw a physician. (Include any pain, symptoms, type of injury.)_____

What date did the above situation begin bothering you?_____

Which side of your body is affected? Left or Right

Please mark on the diagram the location of your symptoms:



List all major medical problems, surgeries, and treatments you have had. (In general, those for which you have been hospitalized.)_____

I have reviewed this form with Harmony Imaging Center Staff before my MRI scan.

Patient's Signature_____