



Bannockburn • Gurnee • Libertyville  
(847) 599-1GRC

### Patient History

Area to be Scanned: \_\_\_\_\_

1. Please describe your symptoms (Please be specific)

\_\_\_\_\_  
\_\_\_\_\_

2. Is this a recurring problem or a new problem? (Please explain)

\_\_\_\_\_  
\_\_\_\_\_

3. Have you had any previous diagnostic testing for this condition?

Type of Examination(s): \_\_\_\_\_

Date of Examination(s): \_\_\_\_\_

Where was the examination(s) performed: \_\_\_\_\_

Results (if known): \_\_\_\_\_

4. Is your pain related to trauma or injury? (Please explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROTOCOL:

## MAGNETIC RESONANCE IMAGING

### Magnetic Safety Questions (Preliminary)

Does patient have:

- |     |     |  |
|-----|-----|--|
| YES | NO  |  |
| ___ | ___ | Cardiac pacemaker  |
| ___ | ___ | Aneurysm clips in head or neck   |
| ___ | ___ | Ear prosthesis (staples, cochlear or hearing aid implant)  |
| ___ | ___ | Implanted electrodes (pain control, seizures, heart rhythm)  |
| ___ | ___ | Claustrophobia (fear of closed spaces)   |
| ___ | ___ | Possibility of being pregnant LMP: _____   |
| ___ | ___ | Surgery in the past two weeks  |
| ___ | ___ | Prior surgery on area to be scanned _____  |
| ___ | ___ | Bullet wounds or shrapnel in the body  |
| ___ | ___ | Do you have a cardiac implantable defibrillator?   |
| ___ | ___ | Have you ever been diagnosed with cancer?  |
| ___ | ___ | Have you ever worked in a machine shop or similar environment where you might have been subject to metal particles in your eyes? |
| ___ | ___ | If yes, did you <b>always</b> wear eye protection?   |

Patient Wt.: \_\_\_\_\_

PAT. NEEDS ORBIT X-RAY FIRST

\_\_\_ Yes \_\_\_ No

Init.: \_\_\_\_\_ Date: \_\_\_\_\_

If the answer to either of the last two questions is "YES", then the patient is informed that he/she may have metal fragments in the eyes that they may not be aware of which could potentially **LEAD TO BLINDNESS**. The patient must obtain orbital x-rays, which may show the fragments. These x-rays must be reviewed by the Radiologist **BEFORE THE MRI SCAN** is to be performed. The patient is informed that these x-rays may not detect all metallic foreign bodies and that if the patient has the MRI, they do so at their own risk.

#### ACKNOWLEDGEMENT:

I have read and understand the Patient Information Survey and agree to be imaged.

Patient's or Guardian's Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Reviewer's Signature: \_\_\_\_\_

Technologist: \_\_\_\_\_ Radiologist: \_\_\_\_\_