Managed by NYMR Solutions

Traumatic Brain Injury Assessment
Diffusion Tensor Imaging
MRI Spectroscopy
Susceptibility Weighted Imaging
NeuroQuant Morphometry
High Resolution Musculoskeletal MRI

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Last Name: ______________________ First Name: ______________________

Phone: (h): ______________ (w): ______________ Cell: ______________

Sex: ☐ M ☐ F Date of Birth: __________ Email: ______________________

Referring Clinician: ______________________ Phone: __________ Fax: __________

Referring Clinician's Signature: ______________________ Date of Signature: __________

Clinical History:

Do you want to schedule a demonstration to view your patients' studies on the internet? ☐ Yes ☐ No
If so, would you prefer a remote demonstration, or would you like us to visit you? ☐ Remote ☐ Visit

Referring Clinician's email: ______________________

DIAGNOSTIC MRI EXAMS

Gadolinium Contrast Injection? ☐ Yes ☐ No

☐ Traumatic Brain Injury (TBI)
- ☐ NeuroQuant
- ☐ Spectroscopy for Known Lesion
- ☐ Trauma Brain (includes SWI)
- ☐ NeuroQuant for TBI
- ☐ DTI (ROI technique) for TBI
- ☐ Single Voxel Spectroscopy for TBI

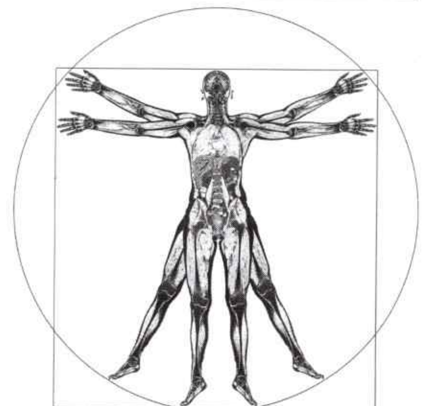
- ☐ Routine Brain
- ☐ ENT
- ☐ TMJs
- ☐ MRA Neck
- ☐ MRA Brain
- ☐ MRV Brain
- ☐ Cervical Spine
- ☐ Thoracic Spine
- ☐ Lumbosacral Spine
- ☐ Sacrum Coccyx

- ☐ MRA Thoracic Aorta
- ☐ MRA Abdominal Aorta
- ☐ MRA Kidneys
- ☐ MRA Lower Extremities
- ☐ MRCP

- ☐ MRI Chest
- ☐ MRI Abdomen
- ☐ MRI Pelvis
- ☐ MRI Pancreas
- ☐ MRI Testicles

Exam		
☐ Shoulder	☐ *L*	☐ *R*
☐ Brachial Plexus	☐ *L*	☐ *R*
☐ Upper Arm	☐ *L*	☐ *R*
☐ Elbow	☐ *L*	☐ *R*
☐ Wrist	☐ *L*	☐ *R*
☐ Hips	☐ *L*	☐ *R*
☐ Thigh	☐ *L*	☐ *R*
☐ Knee	☐ *L*	☐ *R*
☐ Lower Leg	☐ *L*	☐ *R*
☐ Ankle	☐ *L*	☐ *R*
☐ Foot	☐ *L*	☐ *R*

☐ Other: (Specify)
____
____



Transportation is provided when necessary.
Please call our office for more information and appointment scheduling.
Thank you.

MAGNETIC RESONANCE (MRI) PROCEDURE SCREENING FORM FOR PATIENTS

Name ______________________________ Age ________ Height ________ Weight ________
Last name First name Middle Initial

Date of Birth ____/____/____ Male ❑ Female ❑ Body Part to be Examined ____________________

Address ______________________________ Telephone (home) (____) _____-______

City ______________________________ Telephone (work) (____) _____-______

State ______________ Zip Code __________ **Email** ______________________________

Reason for MRI and/or Symptoms ____

Referring Physician ______________________________ Telephone (____) _____-______

1. Have you had a prior? If so please list type, date and location of any diagnostic imaging study (MRI, CT, Ultrasound, X-ray, etc.) of the same body part you are having scanned now.
   ____
   ____
   ____
2. **Do you have any of the following: aneurysm clip, vascular stent, cochlear implant, pacemaker, electronic or magnetic implant or device, any prosthesis (eye, penile, etc,), IUD, piercing, dentures hearing aid, claustrophobia? If so, please describe, and show any card for metallic implants you may have received.** ______________________________
3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❑ No ❑ Yes
   If yes, please describe: ______________________________
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❑ No ❑ Yes
   If yes, please describe: ______________________________
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑ No ❑ Yes
   If yes, please describe: ______________________________
6. Are you currently taking or have you recently taken any medication or drug? ❑ No ❑ Yes
   If yes, please list: ______________________________
7. Are you allergic to any medication? ❑ No ❑ Yes
   If yes, please list: ______________________________
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❑ No ❑ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ❑ No ❑ Yes
   If yes, please describe: ______________________________

For female patients:

10. Date of last menstrual period: ____/____/____ Post menopausal? ❑ No ❑ Yes
11. Are you pregnant or experiencing a late menstrual period? ❑ No ❑ Yes

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 ____/____/____

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

Form Information Reviewed By: ______________________________ ______________________________
Print name Signature

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cellphone, 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.