McLaren Business Products

McLaren Print System Order

Order No: 57774
Order Date: 2020-10-22
User: Lyna Havalda
Phone: 3422203

Ship Location: 2C Attn Lyn
401 S Ballenger Hwy
Flint, Mi 48507
Forms
Quantity: 100
Paragon Dept No: 23012
Dept Name: 2C
Company Number: 60

Order Total Price: 0.00

Item Number: 34104
Item Description: MRI Patient History and Screening Form
Revision Date: 2/2013
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish:
Drill: None
Misc Info:

MRI PATIENT HISTORY AND SCREENING FORM

Patient name _____ DOB ___/___/___ Age _____ Date ___/___/___

MRN: _____ Acct#_____ Phone: (____) _____ Cell: (____) _____

Address: _____ Zip Code: _____ Ht: _____ Wt: _____ Sex: M / F

Referring Physician: _____ Primary Physician: _____

Examination: _____

Diagnosis: _____

Is this problem related to an injury? Yes / No If yes, date of injury: ___/___/___ WC / Auto? _____

Previous MRI related to this problem: Yes / No If yes, when & where: _____

Imaging studies related to this problem: X-ray _____ CT _____

Ultrasound _____ Nuclear Pet _____

Do you have or have you ever had any of the following? Give date and location/procedure.

☐ Yes ☐ No Claustrophobia - scale: _____
☐ Yes ☐ No Heart surgery / Heart valve / Pacemaker _____
*** Patients with a pacemaker / defibrillator cannot be scanned
☐ Yes ☐ No Brain surgery / Brain aneurysm clips _____
☐ Yes ☐ No Eye surgery _____
☐ Yes ☐ No Work around metal shavings / had metal removed from the eyes? _____
☐ Yes ☐ No Shunts / Stents / Intravascular coils _____
☐ Yes ☐ No Orthopedic pins, screws, rods, etc _____
☐ Yes ☐ No Neurostimulator / Bone stimulator _____
☐ Yes ☐ No Previous spine surgery (low back/cervical) _____
☐ Yes ☐ No Ear surgery (cochlear implant implants) or hearing aids _____
☐ Yes ☐ No Electrical, mechanical or magnetic implants _____
☐ Yes ☐ No Implanted drug infusion pump/insulin pump _____
☐ Yes ☐ No History of cancer _____ When _____ Area of body _____
☐ Yes ☐ No Medication Patches _____ Area of body _____
☐ Yes ☐ No Gunshot wounds, shrapnel or BB's _____
☐ Yes ☐ No Any chance of pregnancy / Breast Feeding _____
☐ Yes ☐ No Tattoos / Body piercing / Permanent makeup _____
☐ Yes ☐ No IUD, Diaphragm or pessary? _____
☐ Yes ☐ No Is the patient ambulatory? _____

Drug Allergies: _____
History of previous surgeries: _____
Any kidney function problems: Yes / No Dialysis _____ Kidney Failure _____ Kidney Transplant ___

MANDATORY GFR IF THE PATIENT HAS HISTORY OF KIDNEY DX OR ONE KIDNEY.

GFR _____ DATE DRAWN ___/___/___

Patient's Signature _____ Date _____

Technologist's Signature _____ Date _____ Time _____

Spec Info: