

McLaren Print System Order

Order No: 86839
Order Date: 2024-07-10
User: Deb House
Phone: 989-269-1557

Ship Location: McLaren Thumb - Attn Deb House, Imaging
1100 S VAN DYKE RD
BAD AXE, MI 48413

Forms
Quantity: 100
Paragon Dept No: 27250
Dept Name: MEDICAL IMAGING
Company Number: 530

Order Total Price: 3.35

Item Number: MTR-15
Item Description: MRI Health Assessment
Revision Date: 05/2023
Print: 1 sided black and white
Paper: 20# White Text
Size: 8.5 x 11
Fold:
Finish: None
Drill: None
Poster:
Misc Info:



McLAREN THUMB REGION - PATIENT HEALTH ASSESSMENT
IMAGING DEPARTMENT PHONE: (989) 269-6000 Ext. 4560 • FAX: (989) 269-5209

Name: OOB: CATE:
Exam Ordered: Weight: Physician Name:

Some of the following items may be hazardous to your safety, and may interfere with your MRI examination. Please check the correct answer to each of the following. Do you have:

- Cardiac pacemaker or defibrillator
Surgical clips (head, neck, chest, abdomen)
Implanted drug infusion device
Bone growth / fusion stimulator
Bone treated with rods, pins, plates, screws
Aneurysm clips, staples, wires
Stents, sties, coils, wire placement
Tattooed make-up (eye lines, lips, etc.)
Medication patch
Dentures or partial plates
Chance of pregnancy
Nursing mother
IUD or diaphragm
Kidney disease
Hypertension
Internal pacing wires
Insulin / infusion pump/pen
Eye or ear implant
(Heart / spinal or head)
Metal fragments
Metal wires / mesh
Artificial limb / joint
Body piercings
Hearing aid
Clasping/Pulvis
Scoliosis / diabetes / stroke
Pacite implants
Tattoo
Breast tissue expander
Heart valve replacement
Magnetic Eyelashes

HAVE YOU HAD ANY INJURY TO THE EYE INVOLVING METAL, SUCH AS METAL SHAVINGS, CARBON STEEL, GRINDING METAL, SHRAPNEL, ETC.? Yes No (IF YES, PLEASE INFORM THE MRI TECHNOLOGIST BEFORE COMPLETING THIS FORM.)

Are you allergic to any medication? If so, please list:

Please list all previous surgeries:

Spec Info:

Please explain symptoms / reason for exam:
How long have you had the problem?

Have you had injury or surgery to this area? Yes No Explain

Patient / Guardian Signature: X

Technologist Signature: For hospital staff use only
Contract Injected: Lit Number: Exp. Date: OPR:

Medication Guide Given: Initials:

