Limestone OPEN MRI AND IMAGING CENTER
302-246-2001

# MR INFORMATION FORM

**Name**_____ **DOB** _____**Sex** _____**Weight**_____

**Requesting Physician** _____ **Family Physician** _____

**What symptoms are you experiencing?** _____

**Was there any recent trauma to the affected area?** _____

**Have you ever had cancer? If so, please specify.**_____

**Was there any previous testing for this affected area?** _____

**If so, when and where was it performed?** _____

## The following items can interfere with MRI imaging. Some can be hazardous to your safety.

***PLEASE LET US KNOW IF YOU HAVE ANY OF THE FOLLOWING***

| | | | |
|---|---|---|---|
| **Y / N** | **Cardiac Pacemaker** | **Y / N** | **Hearing Aids** |
| **Y / N** | **Stent or wire in blood vessels/shunts** | **Y / N** | **Cochlear, otologic, or other ear implants** |
| **Y / N** | **Artificial heart valve** | **Y / N** | **Prior gunshot wound** |
| **Y / N** | **Brain aneurysm clips** | **Y / N** | **Facial injury from metal** |
| **Y / N** | **Prosthesis (orbital, joint or penile)** | **Y / N** | **Welding/metal slivers/shavings in eyes** |
| **Y / N** | **Metallic implants** | **Y / N** | **IUD/Pessary** |
| **Y / N** | **Artificial limbs or joint replaced** | **Y / N** | **Pregnant or breast feeding** |
| **Y / N** | **Insulin or drug infusion pump** | **Y / N** | **Trans dermal patch/Neurostimulators** |

**Are you being treated for kidney disease, renal failure, or insufficiency? Y/N** _____

**Females only, date of last cycle?** _____

***I have answered the above questions to the best of my knowledge and understand the information presented to me.***

**Patient Signature** _____ **DATE**_____

**Technologist Signature** _____ **DATE**_____