WARNING: Certain implants, devices or objects may be hazardous and/or may interfere with the Magnetic Resonance (MR) procedure. **DO NOT ENTER** the MRI environment if you have any questions or concerns regarding an implant, device or object. Consult with the MRI Technologist **BEFORE** entering!

Insight Imaging – Patient Demographic and History Form

Patient Information: Last Name:_____ First Name:_____ MI:_____
Date of Birth:_____ SS#:_____ Phone:_____
Home Address:_____ City:_____ State:_____ Zip:_____
Employer:_____ Primary Insurance:_____
Secondary Insurance: _____
Is this visit related to a work injury? (circle one) **YES NO** Is this visit related to an auto accident? (circle one) **YES NO**
Next of Kin Name:_____ Phone #:_____Relationship:_____

Patient Safety Questions: (circle yes or no)

Yes	**No**	Aneurysm Clip(s)?	**Yes**	**No**	Body Piercing Jewelry (remove before MRI)?
Yes	**No**	Cardiac Pacemaker?	**Yes**	**No**	Hearing Aid (remove before entering MRI)?
Yes	**No**	Implanted Cardioverter Defibrillator (ICD)?	**Yes**	**No**	Dentures or Partial Plates?
Yes	**No**	Electronic Implant or Device?	**Yes**	**No**	Breathing Problem or Motion Disorder?
Yes	**No**	Magnetically-Activated Implant or Device?	**Yes**	**No**	IUD, Diaphragm or Pessary?
Yes	**No**	Neurostimulator/Spinal Cord Stimulator?	**Yes**	**No**	Bone Growth/Bone Fusion Stimulator?
Yes	**No**	Internal Electrodes or Wires?	**Yes**	**No**	Cochlear, Ortologic or other Ear Implant?
Yes	**No**	Bone/Joint Pin, Screw, Nail, Wire, Plate?	**Yes**	**No**	Any type of Prosthesis (Eye, Penile, etc.)?
Yes	**No**	Insulin or other Infusion Pump?	**Yes**	**No**	Eyelid Spring or Wire?
Yes	**No**	Implanted Drug Infusion Device?	**Yes**	**No**	Wire Mesh Implant (Hernia)?
Yes	**No**	Heart Valve Prosthesis?	**Yes**	**No**	Any Metallic Fragment or Foreign Body?
Yes	**No**	Artificial or Prosthetic Limb?	**Yes**	**No**	Tissue Expander (i.e., Breast)?
Yes	**No**	Metallic Stent, Filter or Coil?	**Yes**	**No**	Surgical Staples, Clips or Metallic Sutures?
Yes	**No**	Shunt (spinal or intraventricular)?	**Yes**	**No**	Joint Replacement (Hip, Knee, etc.)
Yes	**No**	Vascular Access Port and/or Catheter?	**Yes**	**No**	Do you have a history of Vascular Stents?
Yes	**No**	Medication Patch?	**Yes**	**No**	Radiation Seeds or Implant?
Yes	**No**	Claustrophobia?	**Yes**	**No**	Did you take sedation meds?
Yes	**No**	Metal removed from eyes?	**Yes**	**No**	Eye injury involving metal, silvers or shavings?
Yes	**No**	Have you been injured by a bullet, BB or shrapnel?	**Yes**	**No**	Kidney Disease?
			Yes	**No**	Allergy to IV dye?

For Female Patients: (circle yes or no)

Yes No Are you pregnant **Yes No** Are you currently breastfeeding?

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and/or the MR procedure I am about to undergo.

_____ _____
Signature: (circle one) Patient Relative **Date**

_____ _____
Signature: (circle one) MRI Technologist Medical Assistant **Date**

Insight Imaging Center – MRI Questionnaire

Patient Name:_____ Weight: _____

[redacted] Please fill this section out if exam is: Brain, Spine, Orbit, Face, Neck, MRA Head or Neck

Yes No Have you had an injury to the area under examination? When? _____

Yes No Any pain in the area under examination? How often and where? _____

Yes No Does anything make the pain worse? _____

Yes No Any surgery in the area under examination? When and where? _____

Yes No Do you have any numbness or weakness? _____

Yes No Any palpable mass in the area under examination? Describe? _____

Yes No Any bowel or bladder changes? Describe? _____

Yes No Have you been diagnosed with MS? _____

Yes No Do you have a history of visual problems? _____

Yes No Do you have any history of seizures? Date of last seizure? _____

Yes No Do you have a history of stroke? Date of last stroke? _____

Yes No Do you have a history of dizziness or loss of balance? _____

[redacted] Please fill this section out if exam is **NOT** a Neurological exam.

Yes No Did you have an injury to the area under examination? How and when? _____

Yes No Any pain in the area under examination? How often and where? _____

Yes No Does anything make the pain worse? _____

Yes No Any surgery in the area under examination? When and where? _____

Yes No Any palpable mass in the area under examination? Describe? _____

[redacted] **ALL** patients need to fill this section out.

Yes No Do you have a history of cancer? Type and when? _____

Yes No Radiation? When?_____

Yes No Chemotherapy? When? _____

Yes No Have you ever had another test (MRI, CAT scan, X-ray, Ultrasound or Nuclear Medicine) of the area that is being scanned today? If so, please list what facility and date. _____

Yes No Do you have any other medical conditions? _____

IMPORTANT INSTRUCTIONS

Before entering the MR environment you must remove **ALL** metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, 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.

I acknowledge that the information provided on the patient information form is correct.

_____ _____

Patient Signature Date Witness Signature Date

Insight Imaging

Authorization to Release Protected Health Information

Patient Name:_____ D.O.B:_____

- I authorize Insight Imaging to use and disclose protected health information contained in the patient record indicated above, including as applicable:
    - Treatment, MRI Reports , MRI Films and any medical information requested by my provider or any other physician participating in my care as a patient.
- I authorize Insight Imaging to release any medical information about me to my insurance company and its agents.
- I authorize Insight Imaging to obtain other pertinent studies or test results from outside locations for comparison if deemed necessary.
- I understand that my protected health information that is used or disclosed under the Authorization may be subject to re-disclosure by the recipient and the privacy of my personal health information will no longer be protected by the law.

By signing this Authorization, I acknowledge that I have read and understand the above information.

Patient Name (printed):_____

Patient Signature:_____ Date:_____

Witness Signature:_____Date:_____

Please note below any physician/other person(s) that you would like a copy of your MRI report sent to.

_____

Insight Imaging

Phone: 810-275-9688 Fax: 810-963-1900 www.iinn.com

4800 S. Saginaw Street – Suite 1650 – Flint, MI 48507

Your physician has ordered an MRI to assist in evaluating and treating your symptoms. In some cases, contrast may be injected to better view a specific area.

Please be aware that unlike an X-ray or CT scan that uses ionizing radiation, Magnetic Resonance Imaging (MRI) uses a magnetic field and radiowaves.

You will be asked to remove your clothing and other personal belongings and change into a gown. A dressing room will be provided for you and your belongings which will be lock during your procedure. Please be aware that Insight Imaging is not responsible for anything lost or stolen during your visit.

WARNINGS:

For patients having a contrasted MRI please read the following warning:

Thousands of patients have had a contrasted MRI without problems but we would like you to be aware of the possible complications and/or allergic reactions including; nausea, hives, headaches, pain, bleeding, bruising, swelling, infection and in extremely rare cases death. If you experience any of these conditions you must tell the technologist immediately. There is a physician and emergency medical equipment available to handle these situations.

INSTRUCTIONS:

Before entering the MRI environment you must remove all metallic objects including: hearing aids, dentures, rings, watches, body piercing jewelry, eyeglasses, clothing with metal fasteners, bras with supportive wires, hair pins, barrettes, cellular phone, beeper/pager, money clip, wallet, cards with magnetic strip (credit/debit cards), and keys. Failure to remove these objects will result in damage by the magnetic field.

Some referring physicians maintain equity in Insight Imaging and patients should be aware that they have an option of medical testing facilities. Other MRI imaging facilities include Regional Medical Imaging, McLaren Imaging & Greater Flint MRI.

If you have any questions or concerns, please speak with the Technologist of Staff PRIOR to entering the MRI environment.