MRI SCREENING FORM

Patient Name: ______________________________

Date of Birth: ______________________________

Male   Female   Weight: ____________   Height: ____________

ARE YOU CLAUSTROPHOBIC?   **YES**   **NO**

What symptoms are you experiencing? ______________________________

Referring Physician: ______________________________

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:

- ☐ Aneurysm Clips
- ☐ Cardiac Pacemaker
- ☐ Implanted Cardioverter Defibrillator (ICD)
- ☐ Electronic Implant or Device
- ☐ Magnetically Activated Implant or Device
- ☐ Neurostimulator
- ☐ Spinal Cord Stimulator
- ☐ Internal Electrodes or Wires
- ☐ Bone Growth Stimulator
- ☐ Cochlear, Otologic or Another Ear Implant
- ☐ Insulin Infusion Pump
- ☐ Implanted Drug Infusion Device
- ☐ ANY Type of Prosthesis (Eye, Penile, etc.)
- ☐ Heart Valve Prosthesis
- ☐ Eyelid Spring or Wire
- ☐ Orbital or Eye Implant
- ☐ Injury to Eye Involving Metallic Object or Fragment (e. g., Metallic Slivers, Shavings, Foreign Body, etc.)
- ☐ Injury by a Metallic Object or Foreign Body (e. g., BB, Bullet, Shrapnel, etc.)
- ☐ Artificial or Prosthetic Limb
- ☐ Metallic Stent, Filter, or Coil
- ☐ Shunt (Spinal or Intraventricular)
- ☐ Vascular Access Port and/or Catheter
- ☐ Radiation Seeds or Implants
- ☐ Swan-Ganz or Thermodilution Catheter
- ☐ Medication Patch (Nicotine, Nitroglycerine, Hormone, etc.)
- ☐ Wire Mesh Implant
- ☐ Tissue Expander (e. g., Breast)
- ☐ Surgical Staples, Clips, or Metallic Sutures
- ☐ Joint Replacement (Hip, Knee, etc.)
- ☐ Bone/Joint Pin, Screw, Nail, Wire, Plate, etc.
- ☐ Other ______________________________

DO YOU HAVE A HISTORY OF CANCER?   **YES**   **NO**   **IF YES, WHERE?** ______________________________

ARE YOU ALLERGIC TO ANY MEDICATION?   **YES**   **NO**

IF YES, PLEASE LIST MEDICATIONS: ______________________________

LIST PREVIOUS SURGERIES AND APPROXIMATE DATES: ______________________________

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FEMALE PATIENTS ONLY

- ☐ Is there a chance that you are pregnant?
- ☐ Are you currently pregnant?
- ☐ Have you had a hysterectomy or tubal ligation?
- ☐ Are you currently nursing?

FORM OF BIRTH CONTROL

- ☐ Abstinence
- ☐ Birth Control Pills/Patch
- ☐ Diaphragm
- ☐ Vasectomy
- ☐ Condom
- ☐ IUD
- ☐ Menopause
- ☐ None

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

______________________________   ______________________________
Patient Signature   Date

______________________________   ______________________________
Technologist Signature   Date

BLUE STAR IMAGING
At The Star

HIPAA ACCESS TO PROTECTED HEALTH INFORMATION

Have you had a prior imaging study on the body part you are having examined today? ☐ Yes ☐ No

If yes, what type of exam: CT MRI ULTRASOUND X-RAY

Name of the facility where exam was performed: ______________________________

Date of Service: ______________________________

I hereby authorize Blue Star Imaging to request protected health information onmy behalf for comparison purposes.

______________________________ ______________________________
Signature: Date:

______________________________ ______________________________
Print Name: DOB:

Please Note:

At the request of your primary care physician or referring doctor, your health information and images may be visible to other physicians for continuing your patient care. The purpose of the request could be for a consultation, second opinion, and/or referral to a specialist.

It is to be understood by all parties that the permitted uses and disclosures of health information must be within the scope of the obligations and responsibilities for continued medical care, defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

________ By initialing here, you are helping streamine the process and allowing the consulting physician to view your images without further consent.

If you wish NOT to have your images available for continued care, please let the front desk know and we will note your account accordingly.

In addition to the caregiver(s) providing services and my insurance company for payment of claims, I would like for the following person(s) to have access to my protected health information (PHI).

Name(s)	**Relationship to Patient**
______________________________	______________________________
______________________________	______________________________