

UVA Imaging

415 Ray C. Hunt Dr., Ste 1100
545 Ray C. Hunt Dr., Ste 140
Charlottesville, VA 22903
(434) 243-9198 information



0300004

Patient Identification ↑

Date: _____
month/day/year

Patient name: _____ Height: _____ Weight: _____

Procedure being performed: _____

Please tell us why your physician wants you to have an MRI procedure, i.e. symptoms or medical problems you are experiencing:

Please answer the following questions:

Are you:	Yes	No	Have you ever:	Yes	No
Pregnant or breast-feeding	<input type="checkbox"/>	<input type="checkbox"/>	Been a metal worker	<input type="checkbox"/>	<input type="checkbox"/>
Able to lay flat on your back	<input type="checkbox"/>	<input type="checkbox"/>	Been hit in the eye or face with metal pieces	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobic	<input type="checkbox"/>	<input type="checkbox"/>	Had metal removed from your eyes	<input type="checkbox"/>	<input type="checkbox"/>
Had surgery on your back	<input type="checkbox"/>	<input type="checkbox"/>	Had an MRI examination	<input type="checkbox"/>	<input type="checkbox"/>

Do you:

Have a history of kidney disease, seizure, asthma, or respiratory lung disease

Have any diseases that affect your blood, such as anemia

Have any allergies to medication or MRI Contrast

Please list and describe reaction to medication: _____

Please indicate if you have any of the following:

	Yes	No		Yes	No
Pacemaker, pacing wires or defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Artificial limb or joint	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>	Implanted hardware	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear or other ear implant	<input type="checkbox"/>	<input type="checkbox"/>	plates, pins, screws, rods, wires, etc.		
Eye implant	<input type="checkbox"/>	<input type="checkbox"/>	Tattoo eyeliner* or body tattoo	<input type="checkbox"/>	<input type="checkbox"/>
Nerve or muscle stimulator (TENS unit)	<input type="checkbox"/>	<input type="checkbox"/>	Implanted catheter or tube	<input type="checkbox"/>	<input type="checkbox"/>
Body piercing	<input type="checkbox"/>	<input type="checkbox"/>	Swan Ganz catheter	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Patch drug infusion device (i.e. Nicotine patch)	<input type="checkbox"/>	<input type="checkbox"/>
Bullets, BB's, or pellets	<input type="checkbox"/>	<input type="checkbox"/>	Penile implant	<input type="checkbox"/>	<input type="checkbox"/>
Metal shrapnel or fragments	<input type="checkbox"/>	<input type="checkbox"/>	Ventricular shunt	<input type="checkbox"/>	<input type="checkbox"/>
Diaphragm or intrauterine device (IUD)	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid, dentures, or retainers	<input type="checkbox"/>	<input type="checkbox"/>
Pessary (supporting device placed in vagina)	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Access Port (i.e. portacath)	<input type="checkbox"/>	<input type="checkbox"/>
Implanted drug infusion pump	<input type="checkbox"/>	<input type="checkbox"/>	Magnetic implant anywhere	<input type="checkbox"/>	<input type="checkbox"/>
Coil, stent or filter in a blood vessel	<input type="checkbox"/>	<input type="checkbox"/>	Surgical clips, wires, staples or sutures	<input type="checkbox"/>	<input type="checkbox"/>
Any other implanted item	<input type="checkbox"/>	<input type="checkbox"/>	(If yes, please describe) _____		

*A small percentage of patients with tattooed eyeliner or body tattoos have experienced skin irritation in association with MRI.