ORTHOPEDIC ASSOCIATES OF LANCASTER, LTD

Experienced, Specialized Care

OAL MRI North Pointe
170 North Pointe Boulevard
Lancaster, PA 17601
717-735-6641

OAL MRI Lebanon
1701 Cornwall Road, Suite 200
Lebanon, PA 17042
717-675-1307

Patient Screening Form

Demographic Information

Patient Name: _____ **Study Date:** _____

DOB: _____ **Height:** _____ **Weight:** _____ **MRN:** _____

Prior Surgeries of ANY kind (Type & Date) – Please List:

_____

_____

List Known Allergies: _____

Patient Screening Questionnaire

Procedure/Surgical History

Please put a √ in correct box and answer each question in its entirety.

Pacemaker	☐ YES	☐ NO	
Defibrillator/Implanted Devices	☐ YES	☐ NO	
Neurostimulator	☐ YES	☐ NO	
Loop Recorder	☐ YES	☐ NO	
Heart Valve/Stent/Filter/Coil	☐ YES	☐ NO	Location/Type/Date:_____
Heart or Brain Surgery	☐ YES	☐ NO	Location/Type/Date:_____
Eye or Ear Surgery	☐ YES	☐ NO	Location/Type/Date:_____
Aneurysm Repair	☐ YES	☐ NO	☐ Brain ☐ Abdomen
VP Shunt Device	☐ YES	☐ NO	Location/Type/Date:_____
Back or Neck Surgery	☐ YES	☐ NO	
Any history of metal in your eyes	☐ YES	☐ NO	
Bullets/BBs/Shrapnel inside body	☐ YES	☐ NO	Where is it located:_____

MRI Clearances

Please put a √ in correct box and answer each question in its entirety.

Hearing Aid/Cochlear Implant	☐ YES	☐ NO	
Dentures/Partial Plate	☐ YES	☐ NO	
Tattoos/Permanent Eyeliner	☐ YES	☐ NO	
Latex Allergy	☐ YES	☐ NO	
Implant (clip/pin/plate/screw/rod)	☐ YES	☐ NO	Location/Type/Date:_____
Insulin Pump/Glucose Monitor	☐ YES	☐ NO	Location/Type/Date:_____
Extremity Prosthesis or Brace	☐ YES	☐ NO	Location/Type/Date:_____
Medication Patches	☐ YES	☐ NO	Location/Type/Date:_____
Body Piercing Site(s)	☐ YES	☐ NO	Location/Type/Date:_____
Penile Implant	☐ YES	☐ NO	Location/Type/Date:_____
Chance of Pregnancy	☐ YES	☐ NO	LMP:_____ IUD Brand:_____

Contrast Contraindications

Do you have any of the following?

High Blood Pressure	☐ YES ☐ NO	
Kidney Disease/Renal Failure	☐ YES ☐ NO	If yes, are you on dialysis:_____
Diabetes	☐ YES ☐ NO	
Chronic Liver Disease	☐ YES ☐ NO	
Organ Transplant	☐ YES ☐ NO	
Cancer	☐ YES ☐ NO	Type:_____
	☐ Chemo ☐ Radiation	

Have you ever had an allergy to MRI contrast or reaction to MRI contrast in the past?

☐ YES ☐ NO

Are you actively breastfeeding? ☐ YES ☐ NO

Patient Signature:_____ **Date:**_____