Griffin Imaging, LLC
220 Rock Street
Griffin, GA 30224
(770) 229-4660
Fax:: (770) 229-4632
Specializing In Open MRI, CT & Ultrasound

MRI Patient Screening and History

Patient Information Sheet

PATIENT NAME: _____

AGE: _____ WEIGHT: _____ SEX: € MALE € FEMALE

REFERRED BY DOCTOR: _____

AREA OF CONCERN: _____

_____

SPECIFIC INSTRUCTIONS: _____

_____

_____

Patient History

€ SMOKER or € NON SMOKER

PREVIOUS MRI/CT OR X-RAY? € YES € NO

EXAMINATION: _____

DATES: _____

LOCATION: _____

HAVE YOU EVER BEEN DIAGNOSED WITH CANCER? € YES € NO

PLEASE EXPLAIN: _____

_____

PREVIOUS SURGERY: _____

HEAD: _____

NECK: _____

CHEST: _____

ABDOMEN: _____

EXTREMITIES: _____

OTHER: _____

The following items can interfere with MRI imaging and some may be hazardous to your safety.

Please check if you have any of these items:

_____ Pacemaker
_____ Brain Clips
_____ Brain Aneurysm Clips
_____ Cochlear Implant (Ear)
_____ Aortic Clips
_____ Neurostimulators
_____ Artificial Heart Valve
_____ Insulin Pump
_____ Electrodes
_____ Hearing Aids
_____ IUD
_____ Shunt – Spinal or Ventricular
_____ Joint Replacements
_____ Fractured Bones Treated with Metal Rods
_____ Metal Plates, Pins, Screws, Nails, or Clips
_____ Harrington Rods
_____ Bone or Joint Pins
_____ Prosthesis
_____ Metal Mesh Implant
_____ Wire Sutures
_____ Shrapnel
_____ Dentures
_____ Metal Fragments – in Head, Eyes or Skin

Are you currently on dialysis? _____

Are you in the first trimester of pregnancy? _____

Have you had brain surgery? _____ If so, when? _____

Have you had any surgery or injury where metal objects could still be in your body? _____

If so, when? _____

Any other implants? (Please Explain) _____

_____

_____

I understand that some studies of the head or spine may require a special contrast material to be injected into the bloodstream to improve the accuracy of our study. This drug is considered safe, however a small number of patients may experience an allergic reaction. I have read and understand the above and give consent for this exam and the injection of contrast if necessary.

_____ _____

Patient/ Legal Guardian Date

_____ _____

Witness Date

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MRI Consent Form

Patient Name: _____ Social Security #: _____ Date: _____

INTRODUCTION

Unlike CAT scanning (CT) and some other methods of viewing the body, Magnetic Resonance Imaging (MRI) does not use x-rays but rather uses magnetism and radio waves. As far as we know, M.R.I. is safe. Millions of patients have already been imaged worldwide without apparent difficulty.

PROCEDURE

- You will be interviewed to be certain that you do not have a pacemaker or other implanted electronic device. If you have had brain surgery we must obtain (or you must provide) an x-ray of your head to be certain metallic aneurysm clips were not used.
- If there is any chance of pregnancy, please inform the technologist prior to the exam. Is there any possibility of pregnancy? _____ Please initial_____
- You will be asked to remove your clothes, watch, jewelry (rings excepted), and to change into a hospital gown. A small locker will be provided for your valuables.
- You will enter the scan room and lie on a table that will slide you into the magnet. This is the M.R.I. magnet. Although you will hear repetitive machine-like noise, you will feel nothing abnormal. Ear plugs will be provided. You will be asked to lie still approximately thirty minutes to an hour, or less.
- You will be asked to allow us to access your medical records and other diagnostic examinations for purposes of comparison.
- In certain cases a magnetic contrast agent may be indicated. If this is necessary you will be informed in advance.

RISKS

Extensive evaluation has shown no hazardous effects from M.R.I. Because this is still a relatively new technology, however, long-term effects are unknown. Steps have been taken to exclude metallic objects from the M.R.I. suite.

Your doctor has asked that you have an exam that involves Magnetic Resonance Imaging of the body. This method of examination has the possibility of better defining certain tissues within the body and may improve the diagnostic capability with little known risks to you.

If magnetic contrast is injected, the risks of an allergic reaction (i.e., hives, itching, low blood pressure, headaches, and nausea) are present. Although very rare, a few fatalities have been reported in the medical literature. We will take all steps necessary to handle any reaction that might occur, however, there can be no guarantee regarding the success or results of such treatment.

By signing below, I attest that I have read and understand all of the above and I agree to being scanned by Griffin Imaging, LLC. I have reviewed all of my answers for accuracy and have had the opportunity to ask any questions regarding the information on this form and the examination that I am to undergo.

Signature of Person Completing the Form:_____ Date:_____

Form Completed By: € Patient € Relative € Nurse _____ (Name) _____

Form Information Reviewed By: _____ (Print Name) _____(Signature)

PATIENT HISTORY AND SAFETY SCREENING

Please check any of the below items if applicable to you:

_____ History of allergic reaction to X-ray/IVP/iodinated dyes or contrasts

_____ Allergy to other medications

_____ Other allergies

_____ Asthma, any form

_____ Sickle Cell Anemia

_____ Kidney failure

_____ High Blood Pressure (Hypertension)

_____ Diabetes (High Sugar)

_____ Pacemaker/ Defibrillator

_____ Neurostimulator

_____ Possibility of Pregnancy?

_____ Hearing Aids

Any other Mechanical Implants not listed above: _____

Is your scan today part of any clinical research study associated with the Center for Medicare and Medicaid Services? Yes or No

_____ _____

Patient / Legal Guardian Date

_____ _____

Witness Date

GRIFFIN IMAGING

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Specializing In High Field MRI, CT, Ultrasound & Bone Density Scans
www.griffinimagingradiology.com

RECORD RELEASE FORM

I hereby request and authorize Griffin Imaging, LLC to obtain copies of my medical records and/or x-ray films from _____.

Patient Name: _____

Date of Birth: _____

SSN: _____

Pt Acct #: _____

Exam: _____

Date of Service:_____

Referring Phys.:_____

Please fax any and all records pertaining to the above listed date of service and exam to Griffin Imaging, Attention: Dr. Ronald C. Gay at (770) 229-4632.

_____
Patient Signature

_____
Date

_____
Witness

_____
Date