



Tri-Valley Orthopedic Specialists, Inc.

Solving Musculoskeletal Problems Since 1985

Welcome To Tri-Valley Orthopedics Specialists, Inc. OPEN MRI

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In order to better evaluate and treat your condition, your physician feels that a Magnetic Resonance Image (MRI) is required.

Tri-Valley Orthopedics Specialists, Inc. is able to perform the MRI in our Pleasanton Office.

We must advise you that Tri-Valley Orthopedics Specialists, Inc. has ownership in this diagnostic tool, and that you have the option to choose an outside facility for your MRI. We are happy to refer you to the facility of your choice.

If you elect to have your MRI at TVO, please sign this form and return it to your Physician's Patient Care Coordinator.

Our MRI Technician, Marci, will call your insurance for authorization. Upon approval, she will then call you to schedule your appointment.

We are unable to proceed with your MRI without this information.

Thank you for your understanding.

Pleasanton
4626 Willow Rd.
Pleasanton, CA 94588
tel 925-463-0470
fax 925-463-0473

San Ramon
5601 Norris Canyon Rd.
Suite 130
San Ramon CA 94583
tel 925-275-1133
fax 925-275-1298

Livermore
87 Fenton Street
Suite 105
Livermore, CA 94550
tel 925-373-9182
fax 925-373-2492

Tracy
632 W. 11th Street
Suite 219
Tracy, CA 95376
tel 209-833-6821
fax 925-373-2492

Business Office
5601 Norris Canyon Rd.
Suite 130
San Ramon, CA 94583
tel 925-560-9300
fax 925-560-0648

Name (Please Print)

Signature

Date

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ____/____/____ Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth ____/____/____ Male Female Body Part to be Examined _____

Address _____ Telephone (home) (____) ____-____
month day year

City _____ Telephone (work) (____) ____-____

State _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____ Telephone (____) ____-____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? No Yes

If yes, please indicate the date and type of surgery:

Date ____/____/____ Type of surgery _____

Date ____/____/____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? No Yes

If yes, please list: Body part Date Facility

MRI		____/____/____	
CT/CAT Scan		____/____/____	
X-Ray		____/____/____	
Ultrasound		____/____/____	
Nuclear Medicine		____/____/____	
Other		____/____/____	

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes

If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? No Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes

If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? No Yes

If yes, please list: _____

7. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? No Yes

If yes, please describe: _____

8. Are you allergic to any medication? No Yes

If yes, please list: _____

9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No Yes

For female patients:

10. Date of last menstrual period: ____/____/____ Post menopausal? No Yes

11. Are you pregnant or experiencing a late menstrual period? No Yes

12. Are you taking oral contraceptives or receiving hormonal treatment? No Yes

13. Are you taking any type of fertility medication or having fertility treatments? No Yes

If yes, please describe: _____

14. Are you currently breastfeeding? No Yes

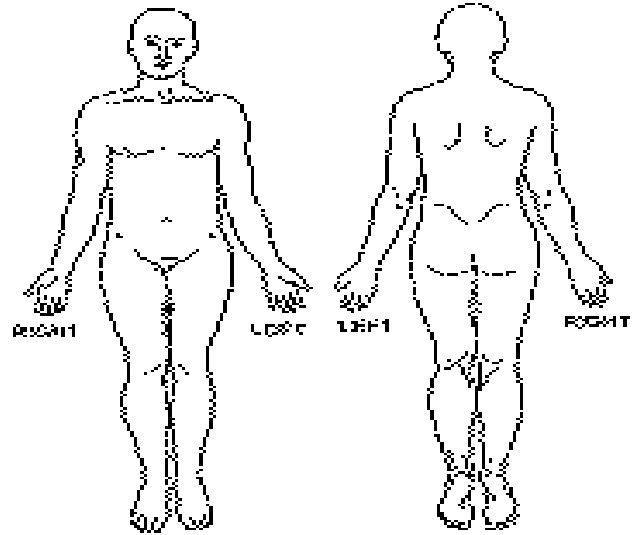


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, 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.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE you enter the MR system room.**

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

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

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: Patient Relative Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature

MRI Technologist Nurse Radiologist Other _____