



# Tri-Valley Orthopedic Specialists, Inc.

Solving Musculoskeletal Problems Since 1985

Kambiz Behzadi, M.D.

## Welcome to Tri- Valley Orthopedic Specialists, Inc Open MRI

Alexandra M. Burgar, M.D.

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

Roger D. Dainer, D.O.

Tri- Valley Orthopedic Specialists, Inc. is able to perform the MRI in our Pleasanton and Tracy locations.

Gregory Horner, M.D.

We must advise you that Tri-Valley Orthopedic 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.

David J. Jupina, M.D.

Steven Liu, M.D.

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

Julie A. Long, M.D.

Our MRI Technician will call your insurance for authorization. Upon approval, you will be called to schedule your appointment.

Anthony J. Porter, M.D.

Shannon M. Rush, D.P.M

Ian Stine, M.D.

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

**Pleasanton**  
4626 Willow Rd.  
Suite 200  
Pleasanton, CA 94588

**Thank you, for your understanding.**

**San Ramon**  
5601 Norris Canyon Rd.  
Suite 130  
San Ramon, CA 94583

**Tracy**  
2180 West Grant Line Rd  
Suite 100  
Tracy, CA 95377

\_\_\_\_\_  
Name (Please Print)

**Medical Office**  
tele 925-463-0470  
fax 925-463-0473

\_\_\_\_\_  
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 \_\_\_\_\_  
month day year

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

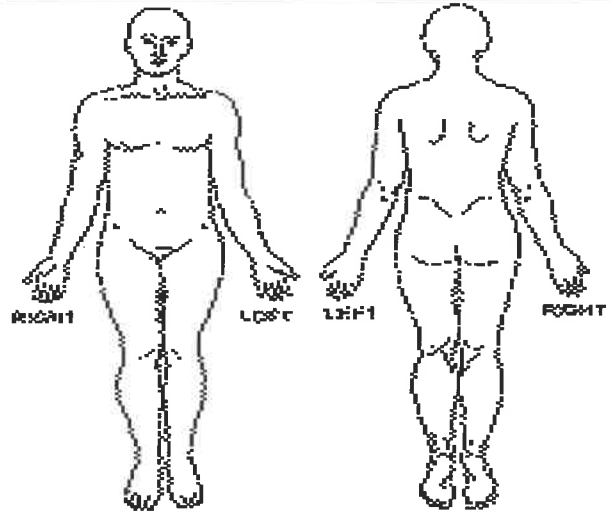


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object.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

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