NEWPORT ORTHOPEDIC INSTITUTE	**22 Corporate Plaza Drive** **Newport Beach, CA 92660** **MRI: (949) 722-7038 ext. 3611**	APPOINTMENT Date:_____ Time:_____

Last Name:_____ First Name:_____ M.I.:_____ Age:_____ Sex: M / F

DOB:_____ Height:_____ Weight:_____ Dominant Hand: Right / Left

Date of Injury:_____ Referring Physician:_____ Occupation:_____

Do you have any of the following? (Please circle YES or NO):

- Pacemaker, pacer wires and/or implanted defibrillator (AICD)? **If yes, please notify us immediately!**---------- Y / N
- Brain aneurysm clip? **If yes, please notify us immediately!**----------Y / N
- Are you pregnant or could be pregnant? **If yes, please notify us immediately!**----------Y / N
- Is this a request for a LUMBAR SPINE MRI?----------Y / N
    - If yes, have you been experiencing low back pain for a month or longer?----------Y / N
- Have you had an MRI scan before?----------Y / N
    - If yes, date of last MRI ___/___/___ What body part was scanned?_____
- Have you ever had surgery on the body part that is being scanned today?----------Y / N
    - If yes, date of surgery ___/___/___ Procedure:_____
- Have you EVER had a metal injury to your eyes?----------Y / N
    - If yes, have you had an MRI since the incident of metal to your eyes?----------Y / N
- History of metal grinding or welding?----------Y / N
- Do you have a personal history of cancer?----------Y / N
    - If yes, please indicate the type of cancer:_____
- Do you have any major medical problems?----------Y / N
    - If yes, please list:_____

Do you have any of the following devices? (Please circle YES or NO):

* Neuro-stimulator	Y / N	* Heart valve	Y / N	* Insulin/infusion/morphine or chemo pump	Y / N
* Bone growth stimulator	Y / N	* Greenfield filter	Y / N	* Shunt	Y / N
* Joint replacements	Y / N	* Vascular stent	Y / N	* Magnetic dental implant	Y / N
* Other metal *(rods, shrapnel, Screws, bullets)*	Y / N	* Tattoos (including eyebrows, eyeliner, lips)	Y / N	* Removable dentures	Y / N
* Wires/sutures/clips	Y / N	* Hearing aids	Y / N	* Penile implant	Y / N
* Inner ear implants *(cochlear, Stapes)*	Y / N	* Harrington rods	Y / N		
		* Electronic devices	Y / N		

What orthopedic problem are we evaluating with today's MRI?

When did the problem first occur?

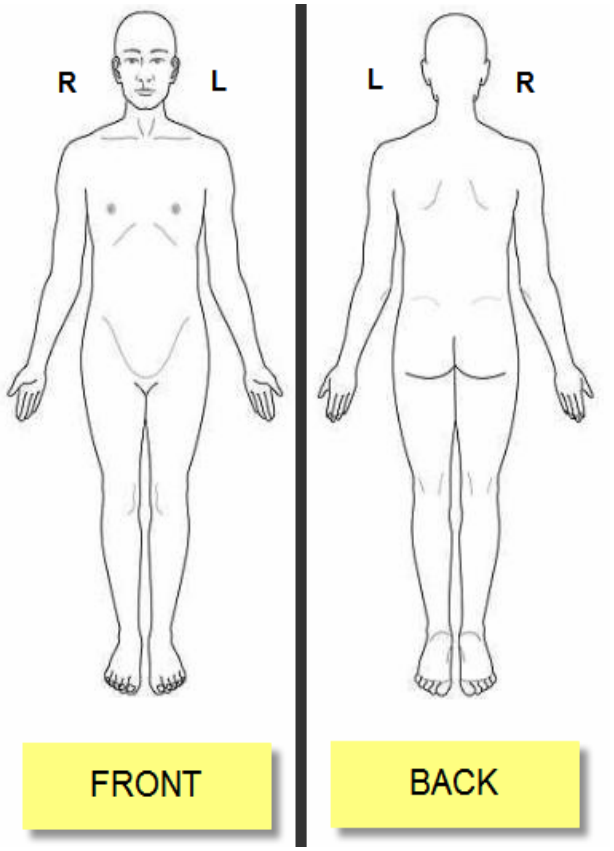
Where exactly is the problem located? (Example: front, back, inside, outside, etc.)

What relieves the symptoms?

Have you had a similar problem before? If yes, when?

What medical imaging tests or treatments have you had for this problem? (Example: Prior MRI, surgery, etc.)

Please indicate on the diagram below any <u>METAL</u> implants inside of or on your body.



<u>NOTES FROM THE TECHNOLOGIST:</u>

PLEASE READ PRIOR TO SIGNING:

You must remove all metallic objects including: easily removable jewelry, bra, shoes, belts, hair pins, safety pins, paperclips, money clips, coins, pens, watch, etc. If you have any body piercing, other than ears, please let the technologist know. Your signature on this form indicates that you authorize and consent to performance of this procedure.

Patient Signature or Representative (if minor) Date

MRI Technologist Date