Hand and Microsurgery Associates

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Lower Extremity MRI Screening Questionnaire

Patient Name: _____ Date: _____

Patient Phone: _____

Patient Number: _____ Exam: _____

Ordering Physician: _____ Auth #: _____

1. What is your chief complaint for visiting us today? _____

2. Was this the result of an accident or injury? Yes No
If yes, when was your accident or injury? _____
Please describe what happened: _____
_____

3. If there was no injury, are the symptoms related to overworking the joint as a result of your job, sport or hobby? Yes No
If yes, what specific motion does your activity require? _____

4. Do your symptoms involve a certain area of the joint? Yes No
If yes, where? (inside, outside, front, back) _____

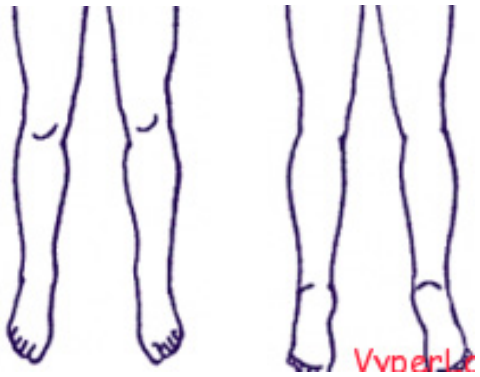
5. Have you had any steroid injections in the joint of interest? Yes No
If yes, when was the injection? _____

6. If you answered "no" to questions 3 and 4, what other known conditions do you think could account for your symptoms? (e.g. arthritis, cancer) _____

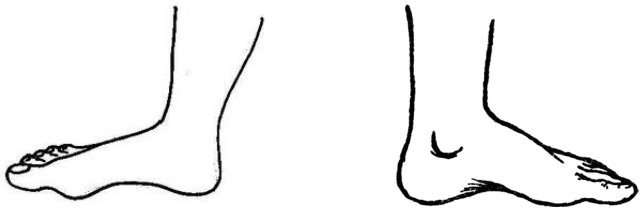
7. Any prior surgery on the area having the MRI?? Yes No
If so, what type of surgery and when? _____

Please indicate the location of your pain on the diagram below

Knee



Foot and Ankle



Patient/Guardian Signature: _____ Date: _____

Please indicate if you have any of the following:

____ Yes ____ No Are you pregnant or trying to be pregnant
____ Yes ____ No Aneurysm clip(s)/ Surgical Clips, staples
____ Yes ____ No Heart valve prosthesis
____ Yes ____ No Cardiac pacemaker
____ Yes ____ No Implanted cardioverter defibrillator (ICD)
____ Yes ____ No Any Electronic implant or device
____ Yes ____ No Neurostimulator
____ Yes ____ No Spinal cord stimulator
____ Yes ____ No Internal electrodes or wires
____ Yes ____ No Bone growth/bone fusion stimulator
____ Yes ____ No Hearing Aids or Cochlear Implant
____ Yes ____ No Insulin infusion pump
____ Yes ____ No Drug infusion device
____ Yes ____ No Bone/joint pin, screw, nail, wire, plate, etc.
____ Yes ____ No Joint replacement (hip, knee, etc.)
____ Yes ____ No Artificial/ prosthetic limb/ other prosthesis
____ Yes ____ No Metallic stent, filter, or coil
____ Yes ____ No Shunt (spinal or intraventricular)
____ Yes ____ No Any implanted ports
____ Yes ____ No Metallic fragment / shrapnel / bullet / BB
____ Yes ____ No Body piercing jewelry/ Tattoos
____ Yes ____ No Any known Allergies If YES please indicate:
_____

FRIENDLY REMINDERS

You must remove all jewelry, hearing aid(s), infusion pumps and metallic items **prior to your examination.**

- Please leave all valuables at home.
- Please arrive 10 minutes prior to your appointment.
- Our facilities are not designed for small children. Please arrange for your children to have outside supervision while you are having your study.

For Contrast patients only:

____ Yes ____ No Recent Blood work for Creatinine, and BUN if applicable
Date: _____
Creatinine: _____ BUN: _____

Staff Use Only:
Lot#: _____
Expiration Date: _____
Contrast Name: _____
Dosage: _____
Location of Injection:
_____

Please read the following pre-exam instructions:

REMOVE ALL JEWELRY, COINS, WATCHES, KEYS, PURSES/WALLETS, CREDIT CARDS, ID CARDS, OR ANYTHING MAGNETIC OR METALLIC FROM YOUR PERSON. THESE THINGS CAN BE AFFECTED BY THE MAGNETIC FIELD (EXPECIALLY CREDIT CARDS AND WATCHES). THEY CAN ALSO CAUSE THE EXAM IMAGES TO BE OF POOR QUALITY.
I have read and understand the above paragraph: _____ (initial here)

Your physician has ordered an MRI to evaluate your condition. Your exam should take about an hour. The results will be back to your physician in approximately three days. There should be no adverse affects after the exam.

Please schedule a follow-up appointment with your Hand and Microsurgery Associates physician for at least three days after your MRI exam has been completed.

I am signing this document giving consent to perform the MRI. If you have questions about the MRI exam, please ask the technologist.
Patient signature:_____ Account Number: _____

Technologist signature: _____ Pre-Cert: _____
Date: _____

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Authorization/Consent for Treatment With Contrast

1. _____ (Please initial) I authorize a qualified representative of Hand and Microsurgery Associates, INC. to inject me with a contrast medium for the purpose of attempting to secure additional diagnostic information during my imaging study. I understand that the contrast medium injection will be done by needle and syringe into the joint or by IV.

2. _____ (Please initial). I understand that: (a) there is a remote risk of death or serious disability associated with any medical procedure; (b) the following are some other risks that may occur with this procedure: allergic reaction, bruising, swelling, nerve damage and infection; and (c) these may result in temporary or permanent injury, impairment, disability or death or the need for additional procedures.

3. _____ (Please initial). I understand that I should immediately report any feelings of discomfort that I believe may possibly be related to the injection to a qualified representative of Hand and Microsurgery Associates, INC. I also understand that I should immediately contact my primary care physician or go to an emergency room if a qualified representative of Hand and Microsurgery Associates, INC. is not available.

4. _____ (Please initial). Prior to the imaging study, I read and answered the imaging questionnaires of Hand and Microsurgery Associates, INC., to the best of my ability. Further, I disclosed all of my allergies, previous surgeries, and current medications (prescription and over-the-counter) on said questionnaire. If I had any questions or uncertainty about the requested information, I noted it and understand that I must speak with a qualified representative of Hand and Microsurgery Associates, INC. about it before the imaging study.

5. _____ (Please initial). The above procedure and its risks have been explained to my satisfaction. I agree that it may be presumed that all of my questions and requests for information were answered to my satisfaction if I undergo the above procedure, because I understand that I have the right to cancel the procedure at any time.

I have read this consent and its contents have been fully explained to me. I hereby certify that I understand the contents of the consent and that I am signing it voluntarily.

_____ _____

Signature of Patient or Legal Guardian/Relationship Date

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