TALLAHASSEE ORTHOPEDIC CLINIC
TALLAHASSEE SPORTS MEDICINE
MRI DEPARTMENT

3334 CAPITAL MEDICAL BOULEVARD, SUITE 700
TALLAHASSEE, FL 32308
(850) 219-1940 • FAX (844) 261-6843

PATIENT INFORMATION

PATIENT

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth _____ Age _____ Social Security # _____

Phone: _____ Occupation: _____ (If Student: ❑ Full or ❑ Part)

Sex: ❑ M ❑ F Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Employer: _____

Address: _____

Describe your medical problem: _____

_____

Referring Physician: _____

Name of nearest living relative/relation: _____ Phone #: _____

❑ Right ❑ Discomfort IMPORTANT: Date of onset or accident: ____/ ____/ _____
❑ Left ❑ Injury If injury: ❑ Work Related ❑ Auto-Accident

INSURANCE

PRIMARY INSURANCE CARRIER

Name: _____

Address: _____

Policy #: _____

Insured's Name: _____

DOB: _____ /_____ /_____

Group #: _____

SECONDARY INSURANCE CARRIER

Name: _____

Address: _____

Policy #: _____

Insured's Name: _____

DOB: _____ /_____ /_____

Group #: _____

Additional Carrier Information: _____

_____

This disclosure form is provided pursuant to and in compliance with Statute 455.25(1), 1992.

Tallahassee Orthopedic Clinic, P.A., 3334 Capital Medical Boulevard, Suite 400, Tallahassee, Florida 32308, wholly owns the Magnetic Resonance Imaging system (MRI) for which you may be referred.

You are not required to obtain items or services but may obtain items or services from the provider or supplier of your choice.

Alternate sources of the items or services for which you may be referred to on Magnetic Resonance Imaging include:

1. Open MRI of Tallahassee, LLC
   2901 Kerry Forest Parkway
   Tallahassee, Florida 32309
2. Tallahassee Neurological Clinic
   Open MRI
   2824-1 Mahan Drive
   Tallahassee, Florida 32308
3. Tallahassee Diagnostic Imaging
   1623 Medical Drive
   Tallahassee, FL 32308
4. Stand Up MRI
   2332 Capital Circle NE
   Tallahassee, Florida 32308

I acknowledge that I have read and understand the foregoing disclosure.

(08/2009) FMI Patient Signature: _____ Date: _____

Tallahassee Orthopedic Clinic
MRI Department

3334 Capital Medical Blvd., Suite 700
Tallahassee, FL 32308
(850) 219-1940

_____ ❑ F ❑ M

Print Name

MRI Screening Form for Patients

Date:_____ /_____ /_____ Time:_____

Have you ever had prior surgery or an operation? . . . . . ❑ Yes ❑ No

If "Yes", please indicate the date and type of surgery:

Date:_____ Type of surgery:_____

Have you had a prior MRI Study? . . . . . ❑ Yes ❑ No

Have you experienced any problem related to a previous MRI exam? . . . . . ❑ Yes ❑ No

If "Yes", please explain:_____

Have you had an injury to the eye involving a metallic object or fragment? . . . . . ❑ Yes ❑ No

If "Yes", please explain:_____

Have you ever been injured by a metallic object (bullet, shrapnel, etc.)? . . . . . ❑ Yes ❑ No

If "Yes", please explain:_____

Are you currently taking any medication or drug? (*Only list narcotics.*) . . . . . ❑ Yes ❑ No

If "Yes", please explain:_____

Do you have a history of asthma, allergic reaction, respiratory disease,
or reaction to a contrast agent used for MRI or CT or X-Ray examinations? . . . . . ❑ Yes ❑ No

Do you have anemia or any disease that effects your blood, a history of kidney disease, or seizures? . . . . . ❑ Yes ❑ No

If "Yes", please explain:_____

FOR FEMALE PATIENTS:

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

Are you currently breastfeeding? . . . . . ❑ Yes ❑ No

Do you have any sort of patch you are wearing, such as a nicotine or nitro patch? . . . . . ❑ Yes ❑ No

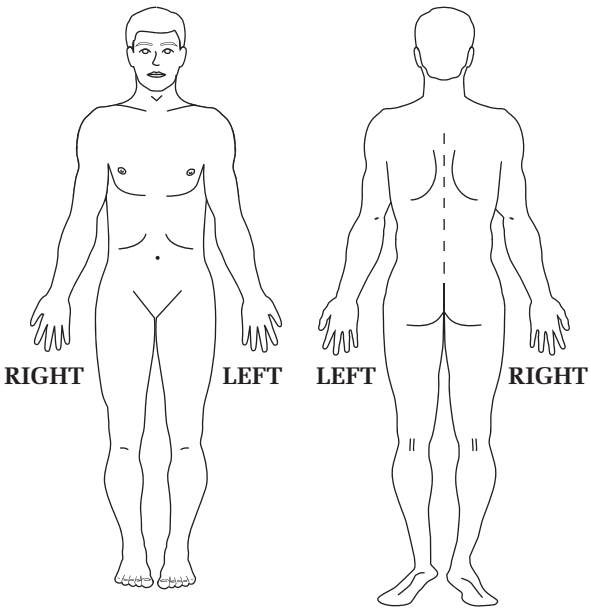
Physician Signature:_____ Pager ID:_____

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 wire
❑ Yes ❑ No Bone growth / bone fusion stimulator
❑ Yes ❑ No Cochlear, audiologic, 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 – any type
❑ 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 Denture 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
❑ Yes ❑ No Have you done welding or grinding?

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, denture, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and 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:_____ /_____ /_____

Form Completed By ❑ Patient ❑ Relative ❑ Nurse (*Print Name*):_____

(*Relationship to Patient*):_____

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