LAKES IMAGING CENTER

2019 South 6th St, Brainerd, MN • Phone: 218.822.6736 • Phone: 877.552.7222 • Fax: 218.822.3758

Date of test: _____ MRN#: _____

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

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: Home: _____ Cell: _____

M ____ F ____ DOB: _____ Age: _____ Social Security#: _____

Who may we speak to on your behalf? _____ Relation: _____

Name of minor parent or guardian: _____
(PLEASE PRINT NAME)

The following questions will help us determine your safety in the MRI scanner. Please answer each question accurately. Please CIRCLE your answer.

Yes **No** Do you have a pacemaker, defibrillator, pain pump, insulin pump or bladder stimulator?
Yes **No** Have you had brain aneurysm surgery with surgical clips?
Yes **No** Do you have Cochlear implant(s)?
Yes **No** Have you had a heart valve replaced?
Yes **No** Do you have magnetic dental implants, magnetic artificial eye or LINX device?

****STOP HERE** if you answered **YES** to any of the questions above. If **NO,** please continue.

Yes **No** Do you wear a neurostimulator or Tens unit?
Yes **No** Do you wear a transdermal medication patch? Where: _____
Yes **No** Do you have a shunt in place for drainage? Date/place: _____
Yes **No** Have you had abdominal aneurysm surgery? When: _____
Yes **No** Have you had brain, inner ear or eye surgery? Type: _____
Yes **No** Do you have a prosthesis/artificial removal body part? Type: _____
Yes **No** Do you have a brace on any body part? Where: _____
Yes **No** Do you have Bravo or M2A endoscopy device? When: _____
Yes **No** Do you have any metal in your body? Where: _____
Yes **No** Do you have a war or gunshot injury? Location: _____
Yes **No** Have you ever done any welding or metal grinding? Eye protection worn: Y / N
Yes **No** Are you pregnant? Due date: _____
Yes **No** Are you breastfeeding?
Yes **No** Do you have an IUD? Type: _____ Date of insertion: _____
Yes **No** Do you wear hearing aids?
Yes **No** Do you have dentures, braces or permanent retainer?
Yes **No** Do you have a history of seizures?
Yes **No** Are you claustrophobic?
Yes **No** Are you allergic to latex, MR contrast, other? What: _____
Yes **No** Have you been diagnosed with high blood pressure?
Yes **No** Do you have tattoos or body piercings?

The information on this page, to my knowledge, is correct.

_____ _____

Patient/Guardian Signature **Date** **Technician Signature** **Date**