

Scheduler: _____ Date & Time of Exam: _____

GREENSBORO IMAGING
MRI SCREENING SHEET

PATIENT NAME: _____ DOB: _____

HOME # _____ WORK # _____ SS#: _____

INSURANCE: _____ MRN# _____

STUDY BEING DONE: _____

REASON FOR STUDY: _____

REFERRING DOCTOR: _____ Sched With: _____

Prior Surgery (Body Part Being Studied) YES NO
.When/Where: _____

Requested Op Notes From _____ Date: _____

SCREENING: Patient Height: _____ Weight: _____

Calling Attempts: _____

YES NO Claustrophobia? Meds? _____ Driver? _____

YES NO Ever Worked Around Metal, Filing, Grinding, Welding?

YES NO Always Worn Protective Glasses?

YES NO Ever Gotten Metal in Eyes?

Orbits Scheduled _____ Date _____ Time _____

YES NO Brain Sx YES NO Inner Ear Sx

YES NO Heart Sx YES NO Pacemaker

YES NO Eye Implants? YES NO Pregnancy?

YES NO Stent (If Yes, Date of Placement _____)

YES NO Hx of Cancer? (If Yes, What Kind? _____)

PREVIOUS: XRAYS _____

CT _____

MRI _____

BONE SCAN _____

Films by: Patient _____ Courier _____ Other _____

Discussed Prep _____ Discussed Length of Study _____ Gave Directions _____

Initials: _____ Date and Time Screened: _____ Call if Cancellation _____