WhyWait Imaging

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Patient Information

Patient Name:

DOB(dd-mm-yyyy):

Gender:

Telephone

Weight **Height:**

Exam Information- To be filled by referring physician

Areas to be scanned:

History:

- History of current or previous work with metal, such as grinding or welding? ☐YES ☐NO
- History of eye injury involving metal or metal fragments? ☐YES ☐NO
  If yes, x-ray clinic patient referred to:_____ phone _____
  Verbal report: **Negative/Positive** Reporting Radiologist Name: _____
- Claustrophobic? (If yes, is the patient taking Ativan & accompanied by family?) ☐YES ☐NO
- Prior MRI, CT scan or Ultrasound of the same area being scanned? ☐YES ☐NO
- If yes, when and at which facility? _____
- Cardiac pacemaker or leads, wires (ever), artificial heart valve? ☐YES ☐NO
- Brain surgery? Aneurysm clips? ☐YES ☐NO
- Any surgeries in the past 6 weeks? Please specify: _____ ☐YES ☐NO
- Any prior surgeries? ☐YES ☐NO
  If yes, please specify date and type of surgery: _____

Stents, coils, or filers in any blood vessel?	☐YES ☐NO	Date:
Implanted electronic/ metallic implants	☐YES ☐NO	Date:
Prothesis: (eye,, penile, leg, arm, joint etc…)	☐YES ☐NO	Date:
Orthopedic pins, rods, screws, plates, staples, nails?	☐YES ☐NO	Date:
Shrapnel, Bullets, BB Pellets or other metal fragments?	☐YES ☐NO	Date:
Dentures, Removable dental devices of magnetic implants	☐YES ☐NO	Date:
Ear implants (cochlear, staples) Hearing aids	☐YES ☐NO	Date:
Transdermal medication patch (Nitroglycerine, hormone, etc)	☐YES ☐NO	Date:
Intrauterine deice (IUD)	☐YES ☐NO	Date:
Body piercing (other than ear) tattoos, permanent makeup	☐YES ☐NO	Date:
Breast tissue expanders	☐YES ☐NO	Date:
Could you be pregnant	☐YES ☐NO	Date:

☐ Allergies: _____ Qualified staff Initial:_____

I attest that the answers I have provided to questions on this form are correct and to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form

Signature: _____(Patient/ Parent/Guardian) Date:_____

Translated by: _____Date: _____

Nothing has changed since last filled out: _____ Date: _____

Referring Physician/NP_____ Signature _____ Date _____

MRI Technologist Signature before entry into the MRI room: _____ Date: _____ If applicable (MRI Tech); Object tested with handheld magnet: _____ Was it ferromagnetic ☐YES ☐NO

Time of testing: _____ Was this patient brought into the room? ☐YES ☐NO