

**ORTHOPAEDIC ASSOCIATES OF READING, LTD.
MRI SCREENING SHEET**

Patient Name: _____

Date: _____ Date of Birth: _____

Please indicate if you have any of the following:

	Yes	No
Cardiac Pacemakers	<input type="checkbox"/>	<input type="checkbox"/>
Brain Aneurysm clips	<input type="checkbox"/>	<input type="checkbox"/>
Aortic clips	<input type="checkbox"/>	<input type="checkbox"/>
Implanted neurotransmitter	<input type="checkbox"/>	<input type="checkbox"/>
Insulin pump	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement/Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Fractured Bones treated with metal rods plates, screws, nails, or clips	<input type="checkbox"/>	<input type="checkbox"/>
Any Surgical Implant	<input type="checkbox"/>	<input type="checkbox"/>
Metal slivers in eyes	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear implants	<input type="checkbox"/>	<input type="checkbox"/>
Shrapnel	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an MRI before?	<input type="checkbox"/>	<input type="checkbox"/>

If so, where and when _____

Patient Height: _____ Weight: _____

Other: _____

NOTE:

Ensure that the following items are removed before scanning:

Purse, wallet, or money clip

Jewelry

Watch, keys, or pocket knife

Credit cards and bank cards with magnetic strips

List all major surgeries: _____

Signature _____ **Date** _____