PREMIER IMAGING
Focused on Providing Superior and Expanded Imaging Care

Encompass Medical Group

PLACE PATIENT STICKER HERE

MRI QUESTIONNAIRE

HEIGHT: _____ WEIGHT: _____

STUDY ORDERED: _____

REASON FOR STUDY: _____

LENGTH OF SYMPTOMS: _____ SURGERY TO AREA? _____

PREVIOUS STUDIES? YES NO DONE WHERE?:_____

IS THIS A RESULT OF AN ACCIDENT? YES NO

ALLERGIES TO MEDICATIONS: _____

DO YOU HAVE/OR HAD CANCER IF SO, WHERE & WHEN: _____

HAVE YOU WORKED AROUND METAL (GRINDING, LATHES, AND WELDING)? YES NO

ANY METAL EVER REMOVED FROM YOUR EYES? YES NO **(IF YES ORBIT XRAYS REQUIRED!!)**

ANY BRAIN/HEART SURGERY, IF SO PLEASE DESCRIBE: _____

If you answer YES to any of the following questions, please tell the receptionist or the technologist!!

CLAUSTROPHOBIC:	**YES**	**NO**	ANEURYSM CLIPS:	YES	NO
ANY IMPLANTS:	YES	NO	PACEMAKER:	YES	NO
CARDIAC DEFIBRILLATOR:	YES	NO	NEUROSTIMULATIOR:	YES	NO
HEART VALVES:	YES	NO	HEART STENTS:	YES	NO
(PLEASE BRING CARD OR INFORMATION ON THE ABOVE TWO DEVICES)					
AORTIC CLIP:	YES	NO	IUD/ DIAPHRAGM:	YES	NO
BODY PIERCINGS:	YES	NO	TATTOOED MAKEUP:	YES	NO
JOINT REPLACEMENTS:	YES	NO	METAL RODS IN BONES:	YES	NO
SURGICAL STAPLES/WIRE:	YES	NO	HARRINGTON RODS:	YES	NO
DRUG PATCHES:	YES	NO	MAGNETIC IMPLANTS:	YES	NO
INTERNAL PACING WIRES:	YES	NO	ELECTRODE PATCHES:	YES	NO
COCHLEAR EAR IMPLANTS:	YES	NO	SWAN-GANZ CATHETER:	YES	NO
INSULIN/INFUSION PUMP:	YES	NO	ACCESS PORTS:	YES	NO
HEART VALVE PROSTHESIS	YES	NO	ANY OTHER PROSTHESIS	YES	NO
SHUNTS (SPINAL/INTRAVENTRICULAR):		YES	NO		
BONE GROWTH STIMULATOR:		YES	NO		

ANY OTHER FOREIGN OBJECTS: PLEASE DESCIRBE: _____

DENTURES OR HEARING AIDS WILL NEED TO BE REMOVED PRIOR TO YOUR MR

Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, and clothing with metal. A locker will be available for your convenience.

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MRI IV CONTRAST CONSENT FORM

Not all MR Exams will require the use of contrast material. Please read and sign this consent form in case your exam will require the use of contrast.

Gadolinium Based intravenous contrast agents, used for MRI procedures, posses a small risk of reactions, which can range in severity from minor to fatal. Complications can be significantly reduced when we properly assess the patient's health status, obtain the medical history and review previous contrast reactions.

Patient Risk Assessment:

Risk Factors

1) Are you diabetic?	YES	NO
2) History of kidney disease/dysfunction	YES	NO
3) Are you allergic to Iodine?	YES	NO
4) History of allergic reaction to any substance?	YES	NO
Please Describe: _____		
5) History of Asthma?	YES	NO
6) Are you on dialysis?	YES	NO
(If YES, dialysis, may be necessary immediately after test)		
7) Are you pregnant?	YES	NO
8) Do you have NSF (Nephrogenic Systemic Fibrosis)?	YES	NO

People who have kidney disease that are given a gadolinium based MR contrast agent my have a very small risk of developing a disease called, Nephrogenic Systemic Fibrosis (NSF). To date this disease has only mainly been found in patients with severe or end stage kidney disease. Your kidney function blood tests will help to determine if you are at an increased risk for developing NSF. If your lab values do not fall with in our set guidelines, no contrast will be given for your procedure.

I, _____, CONSENT to the following procedure _____ with the use of MR Contrast for my exam.
I have been informed of and understand all of the risks involved.

I _____, DO NOT CONSENT to the use of MR Contrast for my exam.

Signature Date

Technologist Date

***For more information on the risks and benefits of contrast material, please ask the technologist.*

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Medical Record Release of Information

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone #: _____

Releasing Clinic or Organization:_____

Receiving Clinic: **Premier Imaging, 373 West 101st Terrace, Kansas City, MO. 64114**

Type of information to be released: **CT, MRI, or Ultrasound of _____for comparison.**

Restrictions: Only medical records that have originated through this health care facility will be photocopied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date the patient signed the authorization.

I understand the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), It may also include information about behavior or mental health services, and treatment for alcohol and/or drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to the authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:**

_____

_____. If I fail to specify an expiration date, event or condition, this authorization will expire one (1) year from the date signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164-524. I understand that my disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient/Parent/Guardian or Authorized Representative Date

_____ _____

Printed Name of Authorized Representative Date

_____ _____

Witness Date

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Patient's Request for Additional Privacy Protection Special Communication Request

In addition to protecting the confidentiality of protected health information as required by law, I request that Encompass Medical Group and Premier Imaging restrict use and disclosure of my protected health information in carrying out treatment, payment or health operation as follows:

_____

_____

_____

I request that you restrict the use and disclosure information such that you do not provide information to:

_____

_____

_____

*(Insert any family members, relative, or other identified persons to whom you **do not** want Encompass Medical Group and Premier Imaging to disclose information).*

I request that communication regarding protected health information provided to me, be provided also by sending material to

_____

Or in the following alternative manner:

_____

_____

_____

I request that you leave detailed voice messages on the following telephone answering machines as needed:

- **Home Phone** (list number):
  _____
- **Work Phone** (list number):
  _____
- **Mobile Phone** (list Number):
  _____

I understand Encompass Medical Group and Premier Imaging may choose to not agree to such restriction(s) but will notify me of its response to my request.

_____

Patient Signature

_____

Signature of Personal Representative of Patient

_____

Description of Representative's Authority to Act for Patient

_____

Date

☐ **REQUEST APPROVED** ☐ **REQUEST DENIED**

_____Encompass Medical Group_____Date