

# CONNECTICUT VALLEY RADIOLOGY, PC

GERARD C. BUFFO, M.D., F.A.C.R.

BRADLEY H. STAEHLE, M.D.

LORI B. GOMEZ, D.O.

## **MRI SCAN SCREENING FORM**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Sex: F M Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Any outside Films: Y N Body Part: \_\_\_\_\_

Where were they performed? \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Did you bring them with you? Y N

Exam Ordered: \_\_\_\_\_ MR # \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Clinical History: \_\_\_\_\_

## **MRI SAFETY FORM**

**Do you have any of the following? If yes please notify the technologist.**

Pacemaker or defibrillator? Y N  
Cerebral aneurysm clips? Y N  
Any chance of metal fragments in your eyes? Y N  
Cochlear implant or staples? Y N  
Any chance of pregnancy? Y N IUD? Y N  
Tattoos? Y N Body Piercing: Y N  
Transdermal medication patches? Y N  
Any bullets, shrapnel, or metal fragments in your body? Y N  
Removable dentures, bridgework or hearing aids? Y N  
Any implants or prosthesis? Y N  
Previous spinal surgery? Y N  
Heart surgery? Y N  
Heart valves and or stents? Y N  
Other surgery? \_\_\_\_\_

**NO WALLETS, WATCHES, KEYS, ELECTRONIC DEVICES, METAL OBJECTS, HAIR PINS, PAPER CLIP, ETC...ARE ALLOWED IN THE SCAN ROOM, LOCKERS ARE PROVIDED**  
**MRI CONTRAST CONSENT**

Allergies? Y N If yes, please list: \_\_\_\_\_

Are you breast feeding? Y N

Asthma, emphysema or diabetes? Y N If yes, please list: \_\_\_\_\_

Any history of Renal Failure ? Y N Are you on dialysis? Y N

**I have thoroughly read, answered and understand the above questions.**

SIGNATURE OF PATIENT OR GUARDIAN \_\_\_\_\_ Date \_\_\_\_\_

SIGNATURE OF PERSON COMPLETING THIS FORM \_\_\_\_\_ Date \_\_\_\_\_

SIGNATURE OF TECHNOLOGIST \_\_\_\_\_ Date \_\_\_\_\_