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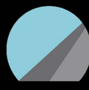
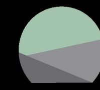
CENTRAL OREGON
RADIOLOGY ASSOCIATES



CASCADE
MEDICAL IMAGING



COMRI
CENTRAL OREGON
MAGNETIC RESONANCE IMAGING

MRI PATIENT INFORMATION

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- ☐ Central Oregon Radiology, Assoc., P.C.
- ☐ Cascade Medical Imaging, LLC - Redmond
- ☐ St. Charles Medical Center˙!˙6 YbX
- ☐ St. Charles Medical Center˙!˙FYXa cbX

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** *Your accurate weight is important!* You may be weighed by the technologist prior to your exam. If your weight exceeds 350 lbs. an alternate study may be recommended by your physician.**

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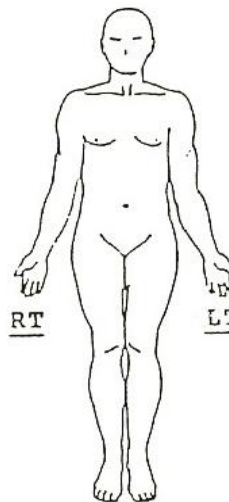

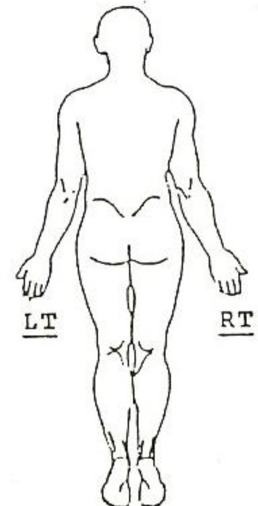

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

FOR OFFICE USE ONLY
PLACE MEDI-TAPE STICKER HERE

THE FOLLOWING ITEMS MAY BE POTENTIALLY HAZARDOUS AND YOU MAY NOT QUALIFY FOR YOUR MRI SCAN. PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

- ☐ Yes ☐ No Cardiac pacemaker or pacemaker wires?
- ☐ Yes ☐ No Brain aneurysm clip(s)?
- ☐ Yes ☐ No Implanted pumps/electronic devices?
- ☐ Yes ☐ No Neurostimulator or mechanical bone growth stimulator?
- ☐ Yes ☐ No Middle ear implant (cochlear, stapes, hearing aids)?
- ☐ Yes ☐ No Any type of intravascular coil, filter, stent, shunt or heart valves?
- ☐ Yes ☐ No Penile prosthesis (implant) or diaphragm/IUD?
- ☐ Yes ☐ No Permanent (tattooed) eyeliner?
- ☐ Yes ☐ No Hemolytic or sickle cell anemia?
- ☐ Yes ☐ No Are you pregnant or do you suspect that you may be pregnant?
- ☐ Yes ☐ No TENS unit?
- ☐ Yes ☐ No Any injury by metallic foreign body, shrapnel or bullet?
- ☐ Yes ☐ No Have you ever had metal in your eyes? Example: From welding, grinding or other metal work?
- ☐ Yes ☐ No If sedation/relaxing medication is necessary - do you have someone to drive you afterward?

Patient signature consenting to sedation/relaxation medication if needed: ______________________
Signature

Do you have **ANY** of the following conditions:

- ☐ Yes ☐ No Are you on dialysis or do you have a history of kidney failure?
- ☐ Yes ☐ No Have you had a kidney removed?
- ☐ Yes ☐ No Are you a diabetic?
- ☐ Yes ☐ No Do you have a history of cancer treated with Chemotherapy?
- ☐ Yes ☐ No Do you have a history of heart disease?
- ☐ Yes ☐ No Are you older than 70?
- ☐ Yes ☐ No Do you have a history of long standing or poorly controlled hypertension?

MRI is usually a very safe medical procedure; however, MRI employs a strong magnet that can move metallic objects within patients. Such movement of metallic objects can have serious consequences for the patient. Please complete this screening form thoroughly to determine if it is safe for you to have an MRI.

I attest that the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form. I hereby give my consent to having a Magnetic Resonance Imaging (MRI) scan including the administration of contrast material if indicated.

Patient or Guardian's Signature: **X** ______________________ Date: ______/______/_______

Print Patient's Name: **X** ______________________

Radiographer's Signature: ______________________

Radiographer - Screening Films Done for Questionable Foreign Body in Orbit(s) ☐ Yes ☐ No

I understand that I am requesting services from Central Oregon Radiology Assoc., P.C. and or Central Oregon Magnetic Resonance Imaging, LLC that may not be approved or covered by my insurance company. Authorization is not a guarantee of payment. Claims payment will be based on member eligibility, medical necessity and benefits in effect at the time of service. I am agreeing to pay for these services personally if these services are not approved or covered.

Patient or Responsible Party Signature: **X** ______________________ Date: ______/______/_______

Witness Signature: **X** ______________________ Date: ______/______/_______