



## MRI PATIENT INFORMATION

Location of your exam

- Central Oregon Radiology, Assoc., P.C.  
 Cascade Medical Imaging, LLC - Redmond  
 Cascade Medical Imaging, LLC - Bend/South Side  
 SCHC:  Bend  Redmond  Madras  Prineville

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  Male  Female \_\_\_\_\_ Age \_\_\_\_\_  
Last First MI

DOB: \_\_\_\_\_ Height \_\_\_\_\_ \*\*Weight \_\_\_\_\_ Referring Physician: \_\_\_\_\_

In the interest of safety, we require that all patients change into a gown for their MRI exam. Additionally, you cannot bring any valuables into the scanning room (including credit cards) so the technologist will lock these up for you outside of the room.

**\*\* 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.**

Briefly describe the problem(s) you are experiencing that made you see your doctor: \_\_\_\_\_

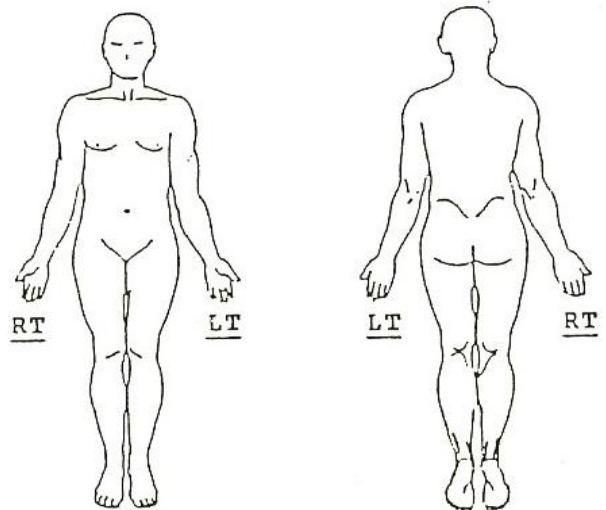
Yes  No Have you had any surgery related to your current problem(s)? \_\_\_\_\_

Yes  No Do you have a personal history of cancer in any part of your body?  
 What part of your body and when was this diagnosis made? \_\_\_\_\_

PERTINENT PREVIOUS STUDIES: X-rays . . . . .  Computed Tomography also known as (CT) (CAT Scan) . . . . .  Ultrasound . . . . .  Nuclear Medicine . . . . .  MRI . . . . .	WHEN and WHERE WERE THEY PERFORMED? _____ _____ _____ _____
---	---

Please use this diagram to mark where you are feeling pain:

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM



**FOR OFFICE USE ONLY**

**PLACE MEDI-TAPE STICKER HERE**

