

## MRI SCHEDULING SHEET

Date Scheduled: \_\_\_\_\_

Circle one: **EIC BIC WIC**

Your Initials: \_\_\_\_\_

*\* Note: If Pt. schedules circle # 8  
If MD office schedules circle # 17*

1. Have you ever been a patient here before? Yes / No If yes, when? \_\_\_\_\_
2. Does the patient have a pacemaker, mitral valve replacement or aneurysm clips? Yes / No
3. Is the patient pregnant or does the possibility exist? Yes / No
4. Has the patient had any metal in the body from prior surgeries including ear surgery (ex. Screws, clips, rods, staples, plates, etc)

5. Has the patient ever been treated for, or exposed to metal fragments in the eyes? Yes / No Had MRI after metal exposure? Yes / No  
Has the patient ever worked at welding, grinding, tool making or other job that created metal fragments? Yes / No
6. Is the patient claustrophobic? Yes / No If yes, have they taken medication prior to previous MRI exams? Yes / No

7. Does the patient have any renal problems? Yes / No If yes, what are they? \_\_\_\_\_  
Is the patient on dialysis? Yes / No If yes, schedule GAD MRI exam same day prior to next dialysis treatment.

Scheduler: GFR if known: \_\_\_\_\_ **40 or less must be brought to attention of radiologist 41-60 must be brought to attention of MR Tech**

8. Patient's Name: \_\_\_\_\_
9. Patient's Phone #s Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

10. Patient's Date of Birth: \_\_\_\_\_ Patient's weight: \_\_\_\_\_ lbs.

11. Insurance Information: MVA  WC  Date of accident/injury: \_\_\_\_\_

A. Name of insurance company: \_\_\_\_\_ PPO HMO 80/20

B. Name of policy holder/guarantor: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

C. If not patient, need SS# & D.O.B. \_\_\_\_\_

D. Address of Insurance Company: \_\_\_\_\_

E. Employer if WC: \_\_\_\_\_

F. Claim # / Pre Cert #: \_\_\_\_\_

G. Name of insurance adjuster: \_\_\_\_\_

H. Number of the insurance company or adjuster: \_\_\_\_\_

12. Type of scan ordered: \_\_\_\_\_

13. Has the patient had previous surgery on that body part? Yes / No

14. Diagnosis/reason for exam: \_\_\_\_\_

15. Does the Rx mention with Gad, Gadolinium or with contrast? Yes / No

16. Does the Rx mention open MRI, high field, closed, 1.5 or 3 Tesla? Yes / No

17. Referring physician: \_\_\_\_\_ Primary physician: \_\_\_\_\_

18. Phone # for referring physician: \_\_\_\_\_ Fax: \_\_\_\_\_

19. Phone # for primary physician: \_\_\_\_\_ Fax: \_\_\_\_\_

20. Has patient had any type of diagnostic imaging (ex. CT, MRI, U/S, X-ray, Nuc Med etc.) done? Yes / No

Type of exam(s): \_\_\_\_\_ Date of exam(s): \_\_\_\_\_

Patient told to pick up and bring prior exams and reports. Yes / No

**\* Tell patient that it is important for our radiologists to have prior exams relating to scheduled exam (for comparison)**