

Orthopedic Physician Associates

MRI Suite • 900 Terry • Suite 100 • Seattle, WA 98104 • 206-694-6665 • Fax 206-694-6676

Patient: _____ OPA Acct. #: _____
Last First M.I.

SS# _____ - _____ - _____ Male Female Age: _____ D.O.B. _____ / _____ / _____
(circle one)

HT: _____ ft. _____ in WT: _____ lb.

Referring Provider: _____ Referring Provider Phone: _____

ARTHROGRAM/MRI <input type="checkbox"/> SHOULDER R / L <input type="checkbox"/> HIP R / L <input type="checkbox"/> KNEE R / L <input type="checkbox"/> ANKLE R / L	MRI SCAN <input type="checkbox"/> C-SPINE <input type="checkbox"/> LOWER EXT R / L <input type="checkbox"/> T-SPINE <input type="checkbox"/> OTHER <input type="checkbox"/> L-SPINE <input type="checkbox"/> KNEE R / L	<input type="checkbox"/> CALL REPORT Phone _____ <input type="checkbox"/> RETURN APPT Phone _____
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History of Injury _____

Clinical Symptoms _____

ICD-9 _____

Has the patient had previous surgery in the region to be scanned? Yes No

If yes, please indicate date and type of surgery: _____
Date Type of surgery

Previous Related Exams (TYPE/Date/Location): _____
(Please include a copy of related exams)

The following questions should be completed by the PATIENT (or by Staff with patient's help)

Are you claustrophobic? Yes No Medications ordered? Yes No

STRONG CONTRAINDICATIONS

The following items are potentially hazardous for you or may interfere with the MRI examination by producing an artifact. Please indicate by circling if you have any of the following:

Cardiac Pacemaker? Yes No Cochlear Implant Yes No

Brain Aneurysm clips? Yes No Pregnancy? Yes No

Neurostimulator/TENS unit? Yes No

Metal in your eyes due to welding, cutting, etc.? Yes No **If Yes, we require screening x-ray**

PRECAUTIONARY INFORMATION

The following items (**) may interfere with imaging but are safe to image 6 weeks after implant. ALL others must be documented.

Metal Mesh? ** Yes No Mechanical Implant? Yes No

Heart valves? ** Yes No Any Prosthesis? Yes No

Stents & Filters? ** Yes No Magnetic Implant? Yes No

Wire Sutures? ** Yes No Vascular Clamps? Yes No

Orthopedic Implants? ** Yes No Ocular Implants? Yes No

(If yes, please explain)

Other (Please explain): _____