ORTHOPEDIC ASSOCIATES

5000 Long Prairie Road, Suite 100
Flower Mound, Texas 75028
(972) 420-1776

Pt Name: _____

DOB: _____ Age: _____

Physician: _____ Weight: _____

Body Part: _____ Height: _____

Please call 214-222-6662 if you check yes to any in the left column.
Please indicate if you have any of the following in your body:

MRI SCREENING FORM

	YES	NO
Programmable Shunt		
Pacemaker/Wires		
Internal Defibrillator		
Cardiac implant device monitor		
Stimulator/Wires		
Epidural/Swan Ganz Catheter		
Tissue Expander		
Surgical Clips		
Cardiac Stent		
Blood Vessel Coil		
Aneurysm Coil		
Cochlear Implant/Ear Implant		
Tracheostomy		
IVC Filter		
Penile Prosthesis		

	YES	NO
Hearing Aid		
IUD		
Eye Implants		
Bullets, BBs, Pellets		
Medication Patch		
Nicotine Patch		
Artificial Limb		
Infusion Pump		
History of Facial Injury		
Pregnant or Breastfeeding		

Date of Last Menstrual Period: _____

Other implanted metal or devices: _____

List all Surgeries w/Dates: _____

_____

_____

I attest that the above information is correct. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form, for the MRI procedure that is about to be performed.

Signature: _____ Print: _____

Relation to the Patient: _____ Date: _____

Technologist: _____ Date: _____