



2405 ATHERHOLT ROAD  
LYNCHBURG, VA 24501

MRI REQUEST

SCHEDULING - (434) 485-8521  
FAX (434) 485-8599

MRI APPOINTMENT DATE: \_\_\_/\_\_\_/\_\_\_  
TIME: \_\_\_\_\_ am pm

PATIENT INFORMATION (PRINT)

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
First M.I. Last

Phone: (\_\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_\_) \_\_\_\_\_

Diagnosis \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Referral/Authorization #: \_\_\_\_\_  
(Attach Front & Back Copy of Insurance Card)

Referring Physician \_\_\_\_\_ Physician Office Contact \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Patient's Weight \_\_\_\_\_

Creatinine \_\_\_\_\_ (copy of lab results to be faxed for contrasted studies)

TYPE OF MRI REQUESTED

- Pelvis
- Hip - R / L
- Extremity
  - Ankle R / L
  - Elbow R / L
  - Foot R / L
  - Hand R / L
  - Knee R / L
  - Shoulder R / L
  - Wrist R / L
  - Other (Specify) \_\_\_\_\_
- Spine
  - C-Spine
  - T-Spine
  - L-Spine

REFERRING PHYSICIAN REQUEST

Send CD of MRI with Patient:   
or  
Send CD of MRI to  
Ordering Physician   
Mail to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Contrast with with/without

Intelemage™

Go to <https://share.intelemage.com> and click "Signup now for a free account" to have results and images sent to you electronically.  
Contact us for more information at 434.485.8521.  
Email: \_\_\_\_\_

Physician's Signature (Required)

Date



### Health History Questionnaire for MRI

**WARNING! If you have impaired kidney function, require kidney dialysis, or have a personal history of kidney disease, please notify a staff member IMMEDIATELY.**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Examination Type \_\_\_\_\_ Examination Date \_\_\_/\_\_\_/\_\_\_

Yes  No Do you have any drug allergies? Please list:

\_\_\_\_\_

Yes  No Are you or could you possibly be pregnant?

Yes  No Are you breast-feeding? Breast milk should be discarded for 48 hours after injection.

Yes  No Have you ever had a previous allergic reaction to MRI contrast?

Yes  No Do you have severe allergies (not minor seasonal allergies)?

Yes  No Do you have asthma?

Yes  No Do you have hemolytic anemia?

Yes  No Do you have sickle cell disease?

Yes  No Do you have a history of kidney disease? Kidney transplant?

Yes  No Do you have severe liver disease? Recent liver transplant or currently awaiting transplant?

Yes  No Do you have poorly controlled hypertension? (Greater than 180/110 mmHg)

Yes  No Do you have cardiomyopathy or congestive heart failure?

Yes  No Do you have diabetes? If yes please answer the following:

Yes  No Are you currently under the care of a physician for your diabetes?

Yes  No Do you have retinopathy? (eye disease related to your diabetes)

Yes  No Do you have neuropathy? (Numbness, tingling, burning in extremities)

Yes  No Do you have heart disease?

Yes  No Do you have a history of stroke or TIA?

Yes  No Do you have any lower extremity problems? (cold feet or legs, infections, sores that won't heal)

Yes  No Are you currently taking any medication containing metformin? These include Metformin (generic), Avandamet, Glucophage, Glucophage XR, Glucovance, Metaglip, Glumetza, Fortamet, Riomet, ACTOPLUS Met, and Janumet.

**I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form, and have had the opportunity to ask questions regarding the information on this form and the procedure I am about to undergo.**

Signature of Person Completing Form: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Signature of Technologist: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

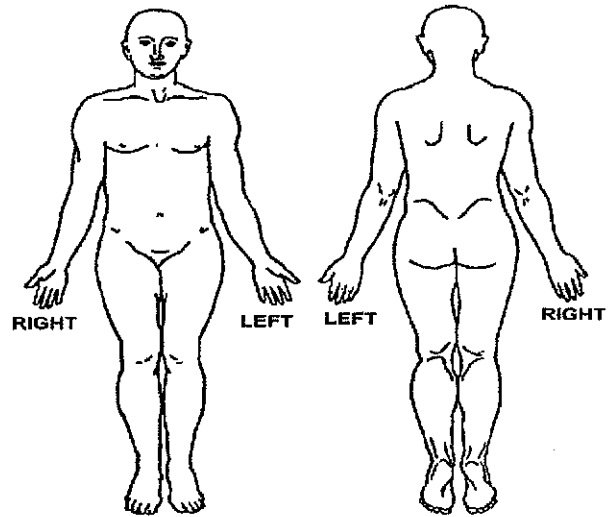


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

**Please indicate if you have any of the following:**

- Yes  No Aneurysm clip(s)
- Yes  No Cardiac pacemaker
- Yes  No Implanted cardioverter defibrillator (ICD)
- Yes  No Electronic implant or device
- Yes  No Magnetically-activated implant or device
- Yes  No Neurostimulation system
- Yes  No Spinal cord stimulator
- Yes  No Internal electrodes or wires
- Yes  No Bone growth/bone fusion stimulator
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Insulin or other infusion pump
- Yes  No Implanted drug infusion device
- Yes  No Any type of prosthesis (eye, penile, etc.)
- Yes  No Heart valve prosthesis
- Yes  No Eyelid spring or wire
- Yes  No Artificial or prosthetic limb
- Yes  No Metallic stent, filter, or coil
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Vascular access port and/or catheter
- Yes  No Radiation seeds or implants
- Yes  No Swan-Ganz or thermodilution catheter
- Yes  No Medication patch (Nicotine, Nitroglycerine)
- Yes  No Any metallic fragment or foreign body
- Yes  No Wire mesh implant
- Yes  No Tissue expander (e.g., breast)
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No IUD, diaphragm, or pessary
- Yes  No Dentures or partial plates
- Yes  No Tattoo or permanent makeup
- Yes  No Body piercing jewelry
- Yes  No Hearing aid  
(Remove before entering MR system room)
- Yes  No Other implant \_\_\_\_\_
- Yes  No Breathing problem or motion disorder
- Yes  No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

**NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.**

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature

Form Completed By:  Patient  Relative  Nurse \_\_\_\_\_  
Print name Relationship to patient

Form Information Reviewed By: \_\_\_\_\_  
Print name Signature

MRI Technologist  Nurse  Radiologist  Other \_\_\_\_\_