Bristol Radiology Center **Truly Open MRI Screening Form** XRef # _____

Pt. Name: _____ **Phone:** _____ **DOB:** _____

Date of Service:_____ **Time:** _____ **Dr.**_____

Previous MRI's or X-Rays: _____

Do you have any of the following?

Y	**N**	1. Cardiac pacemaker?	**Y**	**N**	11. Shrapnel or gunshot wound?
Y	**N**	2. Aneurysm Clips?	**Y**	**N**	12. Joint replacement?
Y	**N**	3. Intracranial clip?	**Y**	**N**	13. Exposure to metal fragments in eye?
Y	**N**	4. Heart Valve?	**Y**	**N**	14. Possibility of pregnancy?
Y	**N**	5. Ear implants?	**Y**	**N**	15. Hearing Aid?
Y	**N**	6. Eye implants?	**Y**	**N**	16. Removable dental work/dentures?
Y	**N**	7. Neurostimulator (TENS unit)?	**Y**	**N**	17. IUD?
Y	**N**	8. Infusion pump?	**Y**	**N**	18. Claustrophobia?
Y	**N**	9. Shunt?	**Y**	**N**	19. Previous surgery?
Y	**N**	10. Vascular clips or stents of any kind?			

Explain " YES" responses: _____

What symptoms (complaints) brought you here today? _____

I have understood and accurately answered all of the above questions.

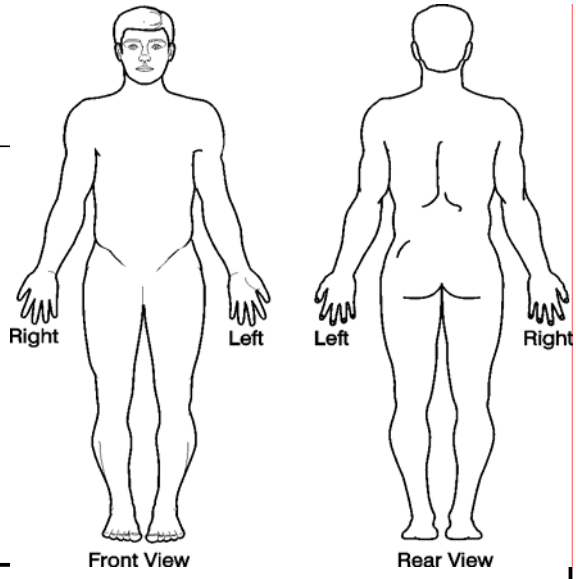
The technologist has answered any questions that I have had regarding the procedure.

Legal guardian , if patient is a minor, or unable to give consent

_____ _____
Signature Date

_____ _____
Printed Name Date

Please color in the area of your concern →



For Office Use Only

Clinical History: **Exam:**

Call Log:

Weight:

Bristol Radiology Center

Open MRI Patient Eligibility / Screening Form

Does patient have any of the following?

1. Cardiac Pacemaker?	**Y**	**N**
2. Aneurysm Clip	**Y**	**N**
3. Ear Implants?	**Y**	**N**

Our office will contact the patient with instructions regarding the exam.

To contact our office call (860) 584- 0541 or ext 4859 or 4863.