ADVANTAGE+ MRI
Excellence in High Field Imaging

Patient Information and Screening

Patient Information

Patient Name: _____
Last First M.I.

Address: _____
Street Number Apt. #

_____
City State Zip

Height: _____ Weight: _____

Sex: _____ Date of Birth: ____/____/____ Age: ____
M/F Mon Day Year

Home Phone (_____) _____

Work Phone (_____) _____

If Work Related, Injury Date: _____

1. Have you ever been a welder, grinder, or sheet metal worker? ❑ Yes ❑ No
   If yes, please explain:
   _____
2. Have you ever had an injury involving a metallic object or fragment? (metallic slivers or shavings)
   If yes, please explain: ❑ Yes ❑ No
   _____

Please indicate if you currently have or ever had any of the following:

Aneurysm clip(s)	❑ Yes	❑ No	Radiation seeds or implants	❑ Yes	❑ No
Cardiac pacemaker	❑ Yes	❑ No	Swan-Ganz or thermodilution catheter	❑ Yes	❑ No
Implanted cardioverter defibrillator (ICD)	❑ Yes	❑ No	Medical patch (transdermal)		
Electronic implant or device	❑ Yes	❑ No	(e.g., Nicotine, Nitroglycerine)	❑ Yes	❑ No
Magnetically activated implant or device	❑ Yes	❑ No	Any metallic fragment or foreign body	❑ Yes	❑ No
Neurostimulator	❑ Yes	❑ No	Wire mesh implant	❑ Yes	❑ No
Spinal cord stimulator	❑ Yes	❑ No	Tissue expander (e.g., breast)	❑ Yes	❑ No
Bone growth/bone fusion stimulator	❑ Yes	❑ No	Surgical staples, clips, or metallic sutures	❑ Yes	❑ No
Internal electrodes or wires	❑ Yes	❑ No	Joint replacement (hip, knee, etc.)	❑ Yes	❑ No
Cochlear, otologic, or other ear implant			Bone/joint pin, screw, nail, wire, plate, etc.	❑ Yes	❑ No
(including hearing aid)	❑ Yes	❑ No	Intrauterine device (IUD), diaphragm,		
Insulin or other infusion pump	❑ Yes	❑ No	or pessary	❑ Yes	❑ No
Implanted drug infusion device	❑ Yes	❑ No	Braces, dentures, or partial plates	❑ Yes	❑ No
Any type of prosthesis (e.g., eye, penile)	❑ Yes	❑ No	Tattoo or permanent makeup	❑ Yes	❑ No
Heart valve prosthesis	❑ Yes	❑ No	Body piercing jewelry	❑ Yes	❑ No
Blood clot filter	❑ Yes	❑ No	Wig or hair implants	❑ Yes	❑ No
Eyelid spring or wire	❑ Yes	❑ No	Hair accessories (e.g., hairpins)	❑ Yes	❑ No
Artificial or prosthetic limb	❑ Yes	❑ No	Other implant	❑ Yes	❑ No
Metallic stent, filter, or coil	❑ Yes	❑ No	Breathing problem or motion disorder	❑ Yes	❑ No
Shunt (spinal or intraventricular)	❑ Yes	❑ No	Claustrophobia	❑ Yes	❑ No
Vascular access port and/or catheter					
(e.g., Broviac, Port-A-Cath, Hickman)	❑ Yes	❑ No			

Pregnant: Y__ N__ How far along _____

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 MR procedure that I am about to undergo.

Signature: _____ Date: _____