ORTHOPAEDIC SURGEONS OF L.I., ASSOC.

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MRI PATIENT DATA SHEET

Study Date:_____ Time:_____

Patient Name:_____ DOB:_____

Phone Number: Home_____ Work_____

Referring Physician:_____ Insurance Carrier:_____

Study Ordered:_____

_____

Patient History

Metal In Eyes ☐Y ☐N
Pacemaker ☐Y ☐N
Metallic Implants ☐Y ☐N
Pregnant ☐Y ☐N
Previous Surgery ☐Y ☐N

Tech Initials

Hair Implants ☐Y ☐N
Head & Neck Surgery ☐Y ☐N
Intracranial Clips ☐Y ☐N

Type:_____

_____

_____

_____

Previous MRI: ☐Y ☐N

Additional History:_____

_____

_____

Patient Signature:_____

6/05