Complete below screening with the patient, then fax or mail with the Physician order to:
Centralized Scheduling - FAX: 231-487-7920, or MAIL: 416 Connable Ave, Petoskey, MI 49770
(Patients cannot be scheduled until both forms have been received.)

INPATIENT & EMERGENT ADD-ON PATIENT: FAX this completed form to: MRI Department
Petoskey Campus Fax: 231-487-7435 / Cheboygan Campus Fax: 231-627-1530

OUTPATIENT Information: Please complete the following questionnaire. Incomplete forms can delay your care. You are required to register 30 minutes prior to your exam time. If you have any questions regarding this form, call 231-487-7204 between 8:30am and 4:00pm Monday – Friday. For questions regarding your scheduled exam date or time, please call scheduling at 231-487-3100 or 1-866-487-3100 between 8:30am and 4:00pm Monday – Friday.

Last Name:	**First Name:**	**MI:**
Phone:	**Cell Phone:**	**Date of Birth:**	☐ **Male** ☐ **Female**

1. Please tell us your **Height**: _____ **Weight:** _____
2. Have you had any prior surgery in the area we are to scan? ☐ Yes ☐ No
   If yes, please list date and type of surgery: _____
3. Have you had any surgery in the past 6 weeks? ☐ Yes ☐ No
   If yes, please list date and type of surgery: _____
4. Do you have any implants in your body? ☐ Yes ☐ No
   If yes, please explain: _____
5. Do you have impaired renal (kidney) function? ☐ Yes ☐ No
   If yes, please explain: _____
6. Have you ever had metal fragments in your eyes? ☐ Yes ☐ No
   If Yes, have they been removed or cleared for MRI? ☐ Yes ☐ No
7. Have you had eye surgery? ☐ Yes ☐ No
8. Are you claustrophobic? ☐ Yes ☐ No
   If yes, what medication was prescribed: _____
9. Have you had prior imaging related to this exam? ☐ Yes ☐ No
   If yes, Facility Name: _____ Phone #: _____

Please indicate if you have any of the following implants/devices etc.…

Cardiac Pacemaker ♦	☐ Yes	☐ No	Shrapnel/BB's ♦	☐ Yes	☐ No
Defibrillator (ICD) ♦	☐ Yes	☐ No	Inner Ear Implants ♦	☐ Yes	☐ No
Valve Replacement ♦	☐ Yes	☐ No	Hearing Aides	☐ Yes	☐ No
Stent ♦	☐ Yes	☐ No	Penile Implant ♦	☐ Yes	☐ No
Coils/Filters ♦	☐ Yes	☐ No	IUD ♦	☐ Yes	☐ No
Brain Aneurysm Clips ♦	☐ Yes	☐ No	Cancer: Primary	☐ Yes	☐ No
Shunt ♦	☐ Yes	☐ No	Pregnant	☐ Yes	☐ No
Insulin Pump ♦	☐ Yes	☐ No	Breast Feeding	☐ Yes	☐ No
Continuous Glucose Monitoring Device ♦	☐ Yes	☐ No	Permanent Eyeliner	☐ Yes	☐ No
TENS Unit	☐ Yes	☐ No	Magnetic Eyelashes	☐ Yes	☐ No
Electronic Tether (must remove)	☐ Yes	☐ No	Body Piercings	☐ Yes	☐ No
Neurostimulator/Spinal Stimulator ♦	☐ Yes	☐ No	Tattoos	☐ Yes	☐ No
Bladder Stimulator ♦	☐ Yes	☐ No	Other Electronic Devices ♦	☐ Yes	☐ No
Esophageal Monitoring Device (BRAVO)	☐ Yes	☐ No	_____	☐ Yes	☐ No

♦ **If you have checked "Yes" to any device above, please indicate below:**

Surgery Date:_____ Device Name:_____

Manufacturer:_____ Model:_____

Patient's Signature:_____ **Date:**_____ **Time:**_____(AM/PM)

For Technologist Use Only

Relative History _____

Technologist Signature: **Date:** **Time:**

McLaren NORTHERN MICHIGAN

MRI (Magnetic Resonance Imaging)
Inpatient & Outpatient Screen
MNM 721.085

R (06/22/2021)