Upright MRI of Colorado

6726 S. Revere Pkwy #100
Centennial, CO 80112

PATIENT NAME: ______________________________ WEIGHT ________

DOB: ____________________ GENDER ☐ Male ☐ Female

1. Have you ever had surgery in the area being scanned? Yes: ☐ No: ☐
2. Have you ever had a prior study to the area being scanned? Yes: ☐ No: ☐

3. Have you ever had Heart, Brain or ear surgery? Yes: ☐ No: ☐
   If Yes, please list:
4. Have you ever had metal in your eyes? Yes: ☐ No: ☐

	Yes	*No*
Cardiac Pacemaker	☐	☐
Cardiac Stent/Filter	☐	☐
Catheter	☐	☐
Pacing Wires	☐	☐
Heart Valves	☐	☐
Tissue Expander	☐	☐
Wire Mesh Implant	☐	☐
Inferior Vena Cava Filter	☐	☐
Aneurysm Clip	☐	☐
Brain Clips	☐	☐
Eyelid Spring or Wire	☐	☐
Cerebral Vascular Coils	☐	☐
Deep Brain Stimulator	☐	☐
Motion disorder	☐	☐

	Yes	*No*
Aortic Clip	☐	☐
Shrapnel/Bullet(s)	☐	☐
Bone Stimulator	☐	☐
Joint Replacement	☐	☐
Joint Prosthesis	☐	☐
Stapes Ear Implant	☐	☐
Hearing Aid (Remove before exam)	☐	☐
Bivona Metal Trach	☐	☐
Metal in Body	☐	☐
Cochlear Implant	☐	☐
Dentures/Partial Plates	☐	☐
Dental Braces	☐	☐
Shunts	☐	☐
Drug Pumps	☐	☐

	Yes	*No*
Medication Patch	☐	☐
Pins/ Nails/Screws	☐	☐
Nerve Stimulator	☐	☐
Infusion Pump	☐	☐
Neurostimulator	☐	☐
Other/Implants	☐	☐
Vascular access port/or catheter	☐	☐
Radiation seeds or implants	☐	☐
Surgical staples/clips /metallic sutures	☐	☐
Tattoo's or permanent make-up	☐	☐
Body piercing jewelry	☐	☐
Breathing problem	☐	☐
Claustrophobia	☐	☐

FOR FEMALE PATIENTS	*Yes*	*No*
IUD (Mirena or Other)	☐	☐
Are you pregnant?	☐	☐
Are you breastfeeding?	☐	☐

Technologist Notes:

X

Patient (Caregiver or Guardian) Signature **Date**

My signature indicates that I have read the patient screening form and I have had the opportunity to ask questions. I agree to have the MRI as indicated and a contrast injection if necessary. **WARNING:** If you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist BEFORE