ZILKHA RADIOLOGY – MRI/CT Patient Form

Office use : Co-pay _____PACS _____ TECH SHEET _____ EMR _____

Referring Doctor: _____

Other Doctors you want your results sent to:

_____

_____

Affix Label Here

Height _____Weight _____ Allergy to **Latex**? **YES NO**

Any chance you are pregnant? **YES NO** Are you currently nursing? **YES NO**

Reason your doctor ordered this exam? _____

_____

Personal history of Cancer? **YES NO** Explain: _____

Any prior Surgery(s)? **YES NO** Explain: _____

Other medical conditions or allergies?_____

MRI patients only: Do you have or have you had?

Cardiac Pacemaker	**YES**	**NO**	Insulin Pump/Pain Pump	**YES**	**NO**	Dentures/Bridges/Retainer	**YES**	**NO**
Metal Fragment in eye	**YES**	**NO**	Mechanical Heart Valve	**YES**	**NO**	Palate Expander	**YES**	**NO**
Defibrillator	**YES**	**NO**	Stent(s) or Filter	**YES**	**NO**	New Tattoo/**less than 6 wks**	**YES**	**NO**
Intracranial Clips	**YES**	**NO**	Back Surgery	**YES**	**NO**	Body Piercing	**YES**	**NO**
Aneurysm Clips	**YES**	**NO**	Abdominal/Vascular Surgery	**YES**	**NO**	Wearing Drug/Pain Patch	**YES**	**NO**
Shrapnel	**YES**	**NO**	Prosthesis	**YES**	**NO**	History of Seizures	**YES**	**NO**
Hearing Aid	**YES**	**NO**	Joint Replacement	**YES**	**NO**			
Neurostimulator	**YES**	**NO**	Metal Sutures	**YES**	**NO**			

If "**YES**" to above, please explain: _____

CAT Scan patients only: Do you have or have you had?

Renal Failure	**YES**	**NO**	High Blood Pressure	**YES**	**NO**	Seizure History	**YES**	**NO**
Sickle cell anemia	**YES**	**NO**	Multiple Myeloma	**YES**	**NO**	Seafood Allergy	**YES**	**NO**
Congestive Heart Failure	**YES**	**NO**	Asthma	**YES**	**NO**			

SMOKING:

☐ Current; Every Day Smoker ☐ Former Smoker ☐ Smoker; Current Status Unknown

☐ Current; Some Days Smoker ☐ Never Smoked ☐ Unknown If Ever Smoked

If Smoker, How many packs per day? _____ For how many years? _____

Are you taking any medications? NO YES List: _____

_____

_____

_____

Do you have an allergy to medications?

NO YES List: _____

_____

Authorization for Treatment: I hereby consent to treatment by the Radiologist and other medical staff for all radiological tests and/or procedures as deemed medically necessary by my referring physician.

I hereby state that the information listed above is accurate to the best of my knowledge.

Print Patient Name: _____ Date of Birth: _____

Patient or Legal Guardian Signature _____Date_____

PT MRI/CT Created 1/21/14