TEMPLETON IMAGING, Inc.

Selma Carlson Diagnostic Center

MRI Procedure Questionnaire

Last Name:	First Name:	MRN:

Date of Exam:	Date of Birth:	Height:	Weight:	Referring physician:

Previous Imaging:

Previous Diagnostic Imaging Procedure(s): (**Related to TODAY'S VISIT ONLY**)

MRI ☐ Yes ☐ No, If yes, Where: _____ When: _____

CT ☐ Yes ☐ No, If yes, Where: _____ When: _____

Personal Medical History:

History of Cancer ☐ Yes ☐ No, If yes, Type: _____

Radiation / Chemotherapy ☐ No ☐ In Progress ☐ Complete, When: _____

Reason for Today's Visit:

Symptoms: _____

_____

How long have you had these symptoms? _____

Extremity Pain? ☐ Yes ☐ No Weakness? ☐ Yes ☐ No Numbness/tingling? ☐ Yes ☐ No

If yes, which side? ☐ Right ☐ Left

Have you had an injury? ☐ Yes ☐ No If yes, Date of Injury: _____

Describe injury: _____

Previous Surgery (**Related to TODAY'S VISIT ONLY**) ☐ Yes ☐ No, If yes, Date of surgery: _____

Type of Surgery / Describe: _____

Your signature below indicates (1) that the information you have provided on this form is true and accurate; (2) that you have received all the information that you desire concerning the diagnostic imaging procedure; and (3) that you authorize and consent to the performance of the diagnostic imaging procedure.

_____ _____

Signature (patient/guardian) Date

If signed by other than patient, please indicate relationship _____

For Office Use Only- Do Not Write Below

Exam(s) Performed: _____ ☐ Previous available for comparison

☐ **STAT Report Required**

☐ Arthrogram Injection: Performed by: _____

☐ IV Injection: Vial amount opened _____ ml Contrast: _____ cc Gad

☐ Right ☐ Left _____ (location) Injected by: _____

Complications: ☐ Yes ☐ No GFR: _____ Drawn Date: _____

Tech Notes: _____

_____Technologist Name: _____