



**145 East 32nd Street  
New York, NY 10016**  
Ph: 212-868-9210 • 888-MRI-2006 • Fax: 212-868-9213  
(Formerly Greater Metropolitan Radiology)  
**www.3TMRI.com**

Patient: \_\_\_\_\_, \_\_\_\_\_ Phone (h) \_\_\_\_\_ (w) \_\_\_\_\_  
Last First

Social Security Number: \_\_\_\_\_ Sex:  F  M Date of Birth: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ E-Mail: \_\_\_\_\_

History: \_\_\_\_\_

Any prior surgery in area of concern?  Yes  No If yes, Date of Surgery: \_\_\_\_\_

Please describe surgery: \_\_\_\_\_

Radiation/Chemotherapy?  Yes  No Date of last treatment? \_\_\_\_\_

Please ask your patient to bring any comparison studies if performed at another facility (CD preferred).

Call with results?  Yes  No Would you like to view studies over the internet?  Yes  No

**EXAM(S) REQUESTED**

**3 Tesla MRI** Intravenous Contrast?  Yes  No  At discretion of Radiologist

Implanted metallic hardware or foreign bodies (model number): \_\_\_\_\_

Whole Brain  Brain, Seizure  IACs  Orbits  Sella  TMJs

Nasopharynx  Soft Tissue Neck  Sinuses  MRA Neck  MRA Brain  MRV Brain

Cervical Spine  Thoracic Spine  Lumbosacral Spine  Sacrum  Coccyx

Shoulder  Left  Right  Brachial Plexus  Left  Right  Upper Arm  Left  Right  Elbow  Left  Right

Wrist  Left  Right  Hips  Left  Right  Thigh  Left  Right  Knee  Left  Right

Lower Leg  Left  Right  Ankle  Left  Right  Foot  Left  Right  Specify joint: \_\_\_\_\_

MRA Thoracic Aorta  MRA Abdominal Aorta  MRA Kidneys  MRA Lower Extremities

MRI Chest  MRI Abdomen  MRI Pelvis  MRCP  MRI Testicles  MRI Prostate

Special attention: \_\_\_\_\_

**CT (16 slice)** Intravenous Contrast?  Yes  No  At discretion of Radiologist

Brain  Orbits  Temporal Bones  Sinuses  Nasopharynx

Cervical Spine  Thoracic Spine  Lumbosacral Spine  Sacrum  Joint (specify) \_\_\_\_\_

Neck  Chest  Abdomen  Pelvis  Renal Stone

CTA Brain  CTA Neck  CTA Thoracic Aorta  CTA Abdominal Aorta

Special attention: \_\_\_\_\_

**Ultrasound**

Carotid  Thyroid  Abdomen  RUQ  Aorta  Kidneys  Pelvis  Transvaginal  Testicular  DVT

Special attention: \_\_\_\_\_

**Both Patient and Physician will receive a CD with all images.**  
High resolution paper reproduction of representative images will be sent with the final report.  
If films of all images are required (possibly totaling 50 sheets of film) please contact us.

**Alpha Imaging Consultants, PLLC**

## General Instructions for Patients:

### All patients, please:

- Arrive 1/2 hour before your scheduled appointment.
- Bring your insurance card; leave jewelry (including any piercings) at home.
- Do not swallow anything except for clear fluids within 4 hours of your exam.
- Please bring any scan performed at another facility for comparison.

### If you are having an MRI exam, please:

- Do not wear makeup or use any hairclips.
- Complete the screening questionnaire before you arrive.
- Obtain the "exact model number" of any heart valve or vascular stent, aneurysm clip or IVC filter within your body from your doctor.

Alpha 3T MRI and Diagnostic Imaging will call you to confirm your appointment the day before your exam.

Feel free to call us at 888-MRI-2006 with any questions or concerns.

We look forward to caring for you.

## DIRECTIONS TO OUR FACILITY

### Local Subway:

- a) 6 train to 33rd Street
- b) B,D,F,V,N,Q,R,W  
to 34th Street, Herald Square  
(walk east or take taxi to our site)

### PATH:

- 33rd Street Station  
(walk east or take taxi to our site)

### By Car:

FDR to 34th Street, left on Lexington

### Local Buses:

98, 101, 102, 103, 16, 34, 1, 21 (near to far)



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**3T MRI**  
*& Diagnostic Imaging*

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# MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient Number \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
Last name First name Middle Initial

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male  Female  Body Part to be Examined \_\_\_\_\_  
month day year

Address \_\_\_\_\_ Telephone (home) (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

City \_\_\_\_\_ Telephone (work) (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_

Reason for MRI and/or Symptoms \_\_\_\_\_

Referring Physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?  No  Yes

If yes, please indicate the date and type of surgery:

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Type of surgery \_\_\_\_\_

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)?  No  Yes

If yes, please list: Body part Date Facility

MRI \_\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

CT/CAT Scan \_\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

X-Ray \_\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

Ultrasound \_\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

Nuclear Medicine \_\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

Other \_\_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_\_

3. Have you experienced any problem related to a previous MRI examination or MR procedure?  No  Yes

If yes, please describe: \_\_\_\_\_

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?  No  Yes

If yes, please describe: \_\_\_\_\_

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?  No  Yes

If yes, please describe: \_\_\_\_\_

6. Are you currently taking or have you recently taken any medication or drug?  No  Yes

If yes, please list: \_\_\_\_\_

7. Are you allergic to any medication?  No  Yes

If yes, please list: \_\_\_\_\_

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination?  No  Yes

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures?  No  Yes

If yes, please describe: \_\_\_\_\_

**For female patients:**

10. Date of last menstrual period: \_\_\_\_/\_\_\_\_/\_\_\_\_ Post menopausal?  No  Yes

11. Are you pregnant or experiencing a late menstrual period?  No  Yes

12. Are you taking oral contraceptives or receiving hormonal treatment?  No  Yes

13. Are you taking any type of fertility medication or having fertility treatments?  No  Yes

If yes, please describe: \_\_\_\_\_

14. Are you currently breastfeeding?  No  Yes

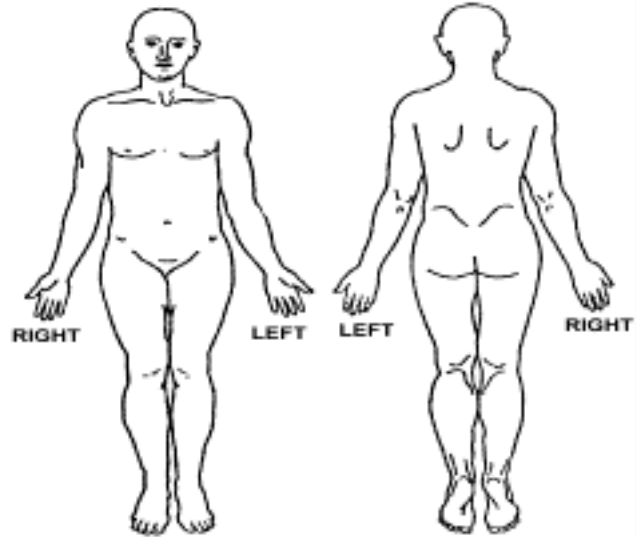


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

**Please indicate if you have any of the following:**

- Yes  No Aneurysm clip(s)
- Yes  No Cardiac pacemaker
- Yes  No Implanted cardioverter defibrillator (ICD)
- Yes  No Electronic implant or device
- Yes  No Magnetically-activated implant or device
- Yes  No Neurostimulation system
- Yes  No Spinal cord stimulator
- Yes  No Internal electrodes or wires
- Yes  No Bone growth/bone fusion stimulator
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Insulin or other infusion pump
- Yes  No Implanted drug infusion device
- Yes  No Any type of prosthesis (eye, penile, etc.)
- Yes  No Heart valve prosthesis
- Yes  No Eyelid spring or wire
- Yes  No Artificial or prosthetic limb
- Yes  No Metallic stent, filter, or coil
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Vascular access port and/or catheter
- Yes  No Radiation seeds or implants
- Yes  No Swan-Ganz or thermodilution catheter
- Yes  No Medication patch (Nicotine, Nitroglycerine)
- Yes  No Any metallic fragment or foreign body
- Yes  No Wire mesh implant
- Yes  No Tissue expander (e.g., breast)
- Yes  No Surgical staples, clips, or metallic sutures
- Yes  No Joint replacement (hip, knee, etc.)
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes  No IUD, diaphragm, or pessary
- Yes  No Dentures or partial plates
- Yes  No Tattoo or permanent makeup
- Yes  No Body piercing jewelry
- Yes  No Hearing aid  
(Remove before entering MR system room)
- Yes  No Other implant \_\_\_\_\_
- Yes  No Breathing problem or motion disorder
- Yes  No Claustrophobia

**Please mark on the figure(s) below the location of any implant or metal inside of or on your body.**



**! IMPORTANT INSTRUCTIONS**

**Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.**

**Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.**

**NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.**

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Signature

Form Completed By:  Patient  Relative  Nurse \_\_\_\_\_  
Print name Relationship to patient

Form Information Reviewed By: \_\_\_\_\_  
Print name Signature

MRI Technologist  Nurse  Radiologist  Other \_\_\_\_\_