



6920 McGinnis Ferry Road
Suite 300
Suwanee, GA 30024
678-835-2299

PATIENT DEMOGRAPHICS

Name: _____ Date of Birth: __/__/____

SSN: ___-___-___ Sex: Male or Female Marital Status: Married/Single/Widowed

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Alternative Phone: _____

Emergency Contact: _____ Relationship: _____

Phone: _____ Alternative Phone: _____

Insurance Plan Name: _____

Policy Holder: _____ Date of Birth: __/__/____

Policy Holder SSN: __/__/____ Relationship to holder: _____

ID Number: _____ Group Number: _____

Johns Creek Diagnostic Center
6920 McGinnis Ferry Road, Suite 300
Suwanee, Georgia 30024

MRI
Patient History & Questionnaire

Name: _____ Date of Birth: _____
Sex: _____ Height: _____ Weight: _____ Age: _____
Referring Physician: _____

Medical History

Please check if you have any of these items:

<i>Pacemaker</i>	_____	Cochlear Implant (Ear)	_____
Brain Aneurysm Clips	_____	Aortic Clips	_____
Heart Stent	_____	Neurostimulators	_____
Heart Valve	_____	Insulin Pump	_____
IUD	_____	Electrodes	_____
Hearing Aids	_____	Shunt- Spinal or Ventricular	_____
Joint Replacement	_____	Hypertension	_____
Metal Rods	_____	Diabetes	_____
Prosthesis	_____	Kidney Disease/Failure	_____
Shrapnel	_____	Liver Disease/Problems	_____
Dentures	_____	Kidney Removed	_____
Metal Fragments (Eyes)	_____	Kidney/Liver Transplant	_____

Are you currently pregnant? _____

List all allergies? _____

List all prior surgeries? _____

What activity caused your present injury: _____

Describe the EXACT location of your pain: _____

When did you FIRST experience this pain? _____

Patient Signature: _____ Date: _____

Please do not write below this line

MR #: _____ Diagnosis: _____

Exam: _____

Comments: _____

Technologist Signature: _____

Contrast Type: _____
Amount: _____
Lot #: _____
Expiration Date: _____
IV ACCESS:
Catheter Size: _____ Time: _____
Site: _____



MRI CONSENT FORM

Patient Name: _____ Date: _____

INTRODUCTION

Unlike CAT scanning (CT) and some other methods of viewing the body, Magnetic Resonance Imaging (MRI) does not use x-ray but rather uses magnetism and radio waves.

PROCEDURE

- You will be interviewed to be certain that you do not have a pacemaker or other implanted electronic device. If you have had brain surgery we must obtain (or you must provide) an x-ray of your head to be certain metallic aneurysm clips were not used.
- If there is any chance of pregnancy, please inform the technologist prior to the exam. Is there any possibility of pregnancy? _____ Please Initial _____
- You will be asked to remove your clothes, watch, jewelry (rings accepted), and to change into scrubs. A small locker will be provided for your valuables.
- You will enter a copper-lined room and lie on a table that will slide you into the magnet. This is the M.R.I. magnet. Although you will hear repetitive machine-like noise, you will feel nothing abnormal. Ear plugs will be provided. You will be asked to lie still approximately thirty minutes to an hour.
- You will be asked to allow us to access your medical records and other diagnostic examinations for the purposes of comparison.
- In certain cases a magnetic contrast agent may be indicated. If this is necessary you will be informed in advance.

RISKS

Extensive evaluation has shown no hazardous effects from M.R.I. Because this is still a relatively new technology, however, long-term effects are unknown. Steps have been taken to exclude metallic objects from the M.R.I. site.

Your doctor has asked that you have an exam that involves Magnetic Resonance Imaging of the body. This method of examination has the possibility of better defining certain tissues within the body and may improve the diagnostic capability with little risks to you.

If magnetic contrast is injected, the risks of an allergic reaction (i.e. hives, itching, low blood pressure, headaches, and nausea) are present. Although very rare, a few fatalities have been reported in medical literature. We will take all steps necessary to handle any reaction that might occur, however, there can be no guarantee regarding the success or result of such treatment.

By signing below, I attest that I have read and understand all of the above and I agree to being imaged by Johns Creek Diagnostic Center. I have reviewed all of my answers for accuracy and have had the opportunity to ask any questions regarding the information on this form and the examination that I am to undergo.

Signature of Person Completing Form: _____ Date: _____
Form Completed By: Patient Relative _____ Nurse _____
Form Information Reviewed By: _____ (Print) _____ (Signature)
Radiological Technologist Radiologist Office Staff Other _____

THERE IS NO CHARGE WHEN ORIGINAL RECORDS ARE SENT TO A PHYSICIAN FOR CONTINUING CARE. A COPYING FEE OF \$10 PER SHEET IS CHARGED THEREAFTER WHEN RECORDS ARE RELEASED TO A PATIENT, OTHER PHYSICIAN, OR THE ORIGINAL ARE LOST BY THE ORIGINAL RECEIPIENT.

Authorization to Receive or Release Medical Information
(Please fill out completely; incomplete forms may delay processing)

1. Explanation

This authorization to receive or release medical information is being requested of you to comply with the terms of the "Confidentiality of Medical Information Act of 1981, Section 56, et. Seq., of the California Civil Code."

2. Authorization

I hereby authorize Johns Creek Diagnostic Center to furnish to :
(Name of physician, hospital or healthcare provider)

_____ (Type of Exam)

Medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for:

(Name of Patient) (Social Security Number) (Date of Birth)

3. I understand that I have the right to limit the type of information to be released. I have indicated below the information that is authorized for release:

All medical information, without exception, including information regarding AIDS and AIDS testing, psychological or psychiatric treatment and drug or alcohol abuse. This includes doctor's notes, labs, x-ray and other diagnostic tests.

All the medical information except the following: _____

Only the following information: _____

4. Uses

This information supplied is to be used for the following purpose (s): continuity of medical treatment

5. Duration

This authorization shall become effective immediately and shall remain in effect until _____ (date).

6. Restrictions

I understand that the recipient may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

7. Additional Copy

I understand that I have a right to receive a copy of this authorization.

Copy requested and provided: yes no

8. I hereby release all parties from any/all legal liability that may arise from the release of this information to the party named above and reserve the right to charge for copies of medical records.

Signed:

_____ Date: _____
(signature)

_____ Witness: _____
(Print Name)

*If signed by other than patient, indicate relationship: _____

*Authorized representative must submit copies of legal document supporting assignment of this authority.