

ID# _____	<b>MID-MICHIGAN MRI SCREENING FORM</b>	DATE ____/____/____
NAME _____	DOB ____/____/____	WT. _____
EXAM(S) ORDERED _____		
REPORT TO ANY OTHER PHYSICIAN _____		

**TO BE FILLED OUT BY THE PATIENT: (please read and sign reverse side of paper)**  
 Some of the following items may be hazardous to your safety and the safety of others, and may interfere with the MRI examination. Please check the correct answer for each of the following.

*Do you have any of the following:*

	YES	NO		YES	NO
Pacemaker or implanted cardiac defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	Artificial limb or joint replacement	<input type="checkbox"/>	<input type="checkbox"/>
Internal pacing wires	<input type="checkbox"/>	<input type="checkbox"/>	Bones surgically treated or replaced with rods, plates, pins or screws.	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm clip or coil	<input type="checkbox"/>	<input type="checkbox"/>	Any type of prosthesis (eye, penile, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Surgical clips, staples or wires in;			Metal or wire mesh implants	<input type="checkbox"/>	<input type="checkbox"/>
head	<input type="checkbox"/>	<input type="checkbox"/>	Any metal fragments/shrapnel in body	<input type="checkbox"/>	<input type="checkbox"/>
neck	<input type="checkbox"/>	<input type="checkbox"/>	Body piercing(s)	<input type="checkbox"/>	<input type="checkbox"/>
chest	<input type="checkbox"/>	<input type="checkbox"/>	Tattooed makeup (eyeliner, lips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Transdermal delivery system (patch)	<input type="checkbox"/>	<input type="checkbox"/>
Intravascular stents, filters, coils or catheters	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia or anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulation system	<input type="checkbox"/>	<input type="checkbox"/>	Any implant held in place by a magnet	<input type="checkbox"/>	<input type="checkbox"/>
Insulin or infusion pump	<input type="checkbox"/>	<input type="checkbox"/>	Endoscopic procedure in last 30 days (Did they use a clip)	<input type="checkbox"/>	<input type="checkbox"/>
Implanted drug infusion device	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease (if yes, specify stage)	<input type="checkbox"/>	<input type="checkbox"/>
Eye or ear implant	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a renal transplant	<input type="checkbox"/>	<input type="checkbox"/>
Bone growth/fusion stimulator	<input type="checkbox"/>	<input type="checkbox"/>	Do you have only one kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shunt (spinal or intrventricular/head)	<input type="checkbox"/>	<input type="checkbox"/>	Lab work in the last 6 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Dentures or hearing aid ( <i>remove before MRI</i> )	<input type="checkbox"/>	<input type="checkbox"/>			
If you are female, any chance of pregnancy	<input type="checkbox"/>	<input type="checkbox"/>			
Are you a nursing mother	<input type="checkbox"/>	<input type="checkbox"/>			

**\*\*HAVE YOU EVER HAD A PENETRATING EYE INJURY INVOLVING A METALLIC OBJECT?**  YES  NO

Form completed by: (Signature and Relation to Patient) \_\_\_\_\_  Patient  Relative:  Physician or other:  
 Email address: \_\_\_\_\_

<p><i>To be completed by MRI Facility</i>  <b>PLEASE EXPLAIN ANY YES ANSWERS: (TYPE OF SURG OR IMPLANT, LOCATION, AND DATE OF SURG)</b></p> <p style="text-align: right;">Implant(s) approved by: _____</p> <p style="text-align: right;">(over) </p> <p>Signature Technologist Reviewing Form AND Scanning the Patient</p>
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**MID-MICHIGAN MRI, INC.  
PAYMENT AUTHORIZATION & RELEASE OF  
INFORMATION**

**Mid-Michigan MRI, Inc. participates with Medicare, Medicaid, Blue Shield and most commercial and managed care insurance plans. For those procedures covered by these plans, Mid-Michigan MRI, Inc. will submit your claim for services rendered and accept reimbursement. However, your insurance carrier may not consider certain MRI procedures benefits. You may also be responsible for your co-pay and deductible amounts as required by your insurance policy.**

**Based on the information provided above, I, the undersigned, authorize payment of medical benefits to Mid-Michigan MRI, Inc. for services described on the attached claim. In the event that my insurance company denies payment, I agree to be responsible for the charges incurred.**

**I hereby authorize Mid-Michigan MRI, Inc. to release medical and financial information related to patient care received on the below date to third party insurance carriers for the charges incurred.**

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**Patient Signature**

**Date**