



THUMB REGION

McLAREN THUMB REGION – PATIENT HEALTH ASSESSMENT

IMAGING DEPARTMENT PHONE: (989) 269-8933 Ext. 4560 • FAX: (989) 269-5209

Name: _____ DOB: _____ DATE: _____

Exam Ordered: _____ Weight: _____ Physician Name: _____

Some of the following items may be hazardous to your safety, and may interfere with your MRI examination. Please check the correct answer to each of the following. Do you have:

Table with 4 columns: Item, Yes, No, Item, Yes, No. Items include Cardiac pacemaker or defibrillator, Surgical clips in head, neck, chest, abdomen, etc.

HAVE YOU HAD ANY INJURY TO THE EYE INVOLVING METAL, SUCH AS METAL SHAVINGS, CARBON STEEL, GRINDING METAL, SHRAPNEL, ETC.? Yes No (IF YES, PLEASE INFORM THE MRI TECHNOLOGIST BEFORE COMPLETING THIS FORM.)

Are you allergic to any medication? If so, please list: _____

Please list all previous surgeries: _____

Please explain symptoms / reason for exam: _____

How long have you had the problem? _____

Have you had injury or surgery to this area? Yes No Explain _____

Patient / Guardian Signature: X _____

Technologist Signature: _____ For hospital staff use only
Contrast Injected _____ Lot Number _____ Exp. Date _____ GFR _____

Medication Guide Given Initials _____

