RIVER OAKS
MRI & DIAGNOSTIC

MRI Spine Patient History

Patient Name: _____ DOB: _____ Age: _____
Height/Weight: _____ MRN: _____Accession #:_____

Body Part to be examined (please circle): **Cervical Spine Thoracic Spine Lumbar Spine**

Please list all symptoms that prompted your MRI (ex: headache, pain, weakness, tingling):
_____
_____
Approximate date of onset of symptoms: _____

Please give a brief description of any accident or trauma, the date of occurrence and the symptoms you are experiencing: _____
_____
_____
_____

-Have you had any past surgeries pertaining to the affected area? _____Yes _____No
If yes, please list the surgeries and their date: _____

-Have you had any previous diagnostic imaging of the affected area? _____Yes _____No
If yes, please list below:
Date: _____ Type: _____ Facility: _____
Date: _____ Type: _____ Facility: _____
-Do you have the report or images with you? _____Yes _____No

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 MRI procedure that I am about to undergo.

Patient/Guardian Signature: _____ Date: _____

OFFICE USE ONLY
Creatinine: _____ GFR(mL/min): _____ Contrast order verified: ____Yes ____No
Contrast used: _____ Contrast amount: _____
IV Location: _____ Inserted by: _____
Expiration Date: _____ Lot # _____
Extravasations: _____Yes _____No
Tech Notes: _____
_____
_____
_____

Tech Initial: _____ Date: _____
Paramedic Initial: _____ Date: _____