

TRUE MEDICAL IMAGING

Patient Name: Chart Number:

1. Have you ever had heart surgery?\_\_

If so, what **month**, **date**, and **year**?\_\_

1. Do you have a pacemaker?
2. Have you ever had any form of Brain Surgery?\_ \_

If so, what **month**, **date**, and **year**?\_\_

1. Do you have aneurysm clips?\_\_
2. Are these aneurysm clips MRI safe?\_
3. Do you carry a card that specifies that the clips are MRI safe?\_
4. Do you have pacing wires?\_\_
5. Do you have Cardiac Valves that are not MRI safe?\_

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Patient Signature Date

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Technologist Signature Date

TO BE COMPLETED BY SCANNING TECHNOLOGIST

100% Veteran Owned and Operated R 052216