PAIN SHEET Spine Evaluation

Last Name	First	Middle Init.	Age	Weight

THESE QUESTIONS APPLY ONLY TO THE AREA BEING SCANNED TODAY

1. What was your chief complaint when you visited your Doctor?______________________________

   ____

2. What does your Doctor think is causing your back pain? ______________________________

   ____

3. How long have you had this pain? ____

4. Does the pain go down your arm? _______ Leg?________ Back?_______ Front?__________

   Left? ____________ Right?_____________________ Both?_________________________

5. Do you have any numbness? ____

   Do you have any weakness? ____

6. Have you had bowel or bladder changes? ______________________________________

7. Have you had surgery or arthroscopy to the area being scanned today ?________________

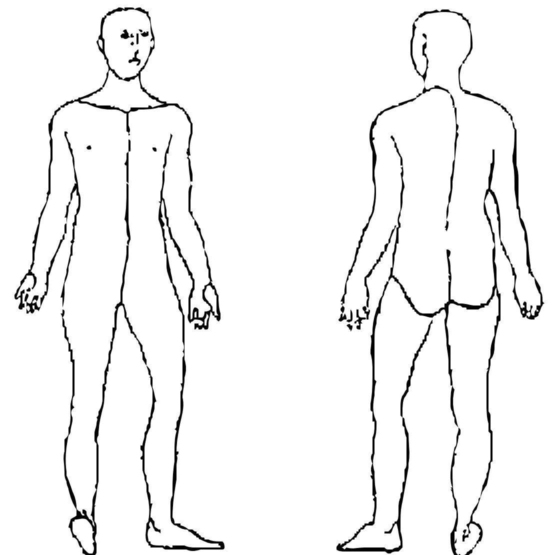
   When?______ What was done? ________________

   ____

8. Do you have a history of cancer?_______________

9. Do you have any other medical conditions?

   ____



PLEASE SHADE IN THE AREAS WHICH HURT

PLEASE COMPLETE THE FOLLOWING FORM

Patient History and Safety Screening

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

Have you ever had an MRI with us? ___________ If yes, when? ________________________

Do you have a follow-up appointment with your doctor? Yes No
If yes, date: ________________ Time: _______________

YES	NO		YES	NO	
?	?	Cardiac pacemaker	?	?	Brain vessel clips
?	?	Aortic clips	?	?	Artificial heart valve
?	?	Insulin pump	?	?	Electrodes
?	?	Ear surgery or implants	?	?	Hearing aids
?	?	Coronary, artery or heart surgery. If yes, when? ______________________________			
?	?	Tens Unit or Pain Stimulating Unit			
?	?	Metal fragments in the head, eye or skin			
?	?	Have you ever worked with metal or as a metal worker?			
?	?	Do you have any metal plates, pins, screws, nails or clips?			
?	?	Any previous brain surgery? If yes, what was the surgery for? ____________________			
?	?	Is there any chance you are pregnant? (MRI is not recommended for women in their first trimester of pregnancy)			

PATIENT CONSENT

MEDICARE AUTHORIZATION AND ASSIGNMENT

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information necessary for this or a related Medicare/Medigap/other insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature: ____ Date: _____________

RECEIPT OF PRIVACY NOTICE

I acknowledge receipt of the Longview Orthopedic Associates Notice of Privacy Practices.

CONTRAST INJECTION

MRI contrast medium is sometimes administered to patients during the exam to enhance the visibility of certain tissues in the body. If you are breast-feeding contrast is contraindicated. Otherwise, there are no contraindications for this injection (except those who have prior allergic reaction to this contrast, which is very rare). I hereby authorize Pacific Imaging Center to administer an IV (intravenous) MRI contrast medium if necessary during the MRI examination. Pacific Imaging Center is hereby authorized to be furnished with any and all medical information (including but not limited to Hospital records, reports, x-rays, and opinions), pertaining to the patient. I authorize the release of any necessary medical information to Pacific Imaging Center to assist in my diagnosis.

I have read, understood, and hereby consent to the MRI examination and the above conditions.

Signature of Patient: ____ Date _____________

Signature of Parent or Guardian: __________________________________ Date _____________

PLEASE COMPLETE BOTH SIDES