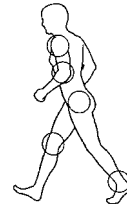


# FAR OAKS ORTHOPEDISTS INC.

Timothy P. Quinn MD  
 Steven M. Kleinhenz MD  
 John J. Lochner III MD  
 Donald W. Ames MD

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 Aram M. Donigian MD  
 James Willey, MPAS, PA-C

Sharilyn Hamilton, MSN, APRN-BC



## MRI SCREENING SHEET

Patient Name: \_\_\_\_\_ Weight: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Body Part:  Left  Right  Knee  Shoulder  Other: \_\_\_\_\_

Physician Ordering MRI:  Quinn  Kleinhenz  Lochner  Ames  Dunaway  Welker  Donigian  
 James Willey, MPAS, PA-C  Sharilyn Hamilton, MSN, APRN-BC

***Please indicate if you have any of the following:***

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Breast Tissue Expanders .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemakers .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Brain Aneurysm Clips.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Aortic Clips.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Implanted Neurotransmitter .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin Pump .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing Aids.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint Replacement .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Fractured bones treated w/metal rods<br>plates, screws, nails, or clips..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Prosthesis .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Worked around metal .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Metal slivers in eyes.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Cochlear Implants .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Shrapnel .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnancy .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Claustrophobic.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had an MRI before? .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |

If so, where and when: \_\_\_\_\_

Other: \_\_\_\_\_

List all major surgeries: \_\_\_\_\_

\_\_\_\_\_

I authorize Far Oaks, Inc. to release to the insurance carrier or any other person responsible for payment any information including medical to process my claims. I permit a copy of the authorization to be used in the place of the original. I certify that all the information I have given is true and correct. I authorize direct payment be made to the physicians of Far Oaks, Inc. All services not covered by my insurance company are the responsibility of the patient and/or responsible person.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_