



**Patient Information:** Name: \_\_\_\_\_ MI: \_\_\_\_\_ Exam Date: \_\_\_\_\_ Time: \_\_\_\_\_

Procedure: \_\_\_\_\_ Doctor: \_\_\_\_\_

Reason for Exam: \_\_\_\_\_ CC: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_ DOB: \_\_\_\_\_

Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Marital Status: M S W D Sep SSN: \_\_\_\_\_ M / F

Patient's Employer: \_\_\_\_\_

Spouse/Responsible Party: \_\_\_\_\_

Responsible Party DOB: \_\_\_\_\_ Responsible Party SSN: \_\_\_\_\_

Responsible Party Employer: \_\_\_\_\_

**Insurance Information:** Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Pre-cert required? Yes / No

Subscriber: \_\_\_\_\_ ID #: \_\_\_\_\_ Group: \_\_\_\_\_

Deductible/Co-Insurance: \_\_\_\_\_

Claims Address: \_\_\_\_\_

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

Subscriber: \_\_\_\_\_ ID #: \_\_\_\_\_ Group: \_\_\_\_\_

Deductible/Co-Insurance: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Worker's Comp: CS # \_\_\_\_\_ Injury Date: \_\_\_\_\_ Employer: \_\_\_\_\_

**Other Studies:** \_\_\_\_\_

**Medical Background:**

Pacemaker, CAGB, or stent? Yes No

Ever had brain surgery? Aneurysm? Yes No

Inner ear prosthesis (i.e. cochlear implant)? Yes No

History of back surgery? Level \_\_\_\_\_ Yes No

History of renal disease, diabetes, DOB  $\geq$  1950? Yes No

**Creatinine level needed? Level:** \_\_\_\_\_ Yes No

Does the patient have hx of CA? Yes No

Shrapnel/metal fragments? Yes No

Ever had metal in their eyes? Yes No

History of MRSA? Yes No

**Claustrophobic?** Yes No

History of Seizures? Last seizure \_\_\_\_\_ Yes No

Possible pregnancy? Yes No

Permanent eyeliner? Yes No

Dentures? Yes No

Is the patient wheelchair bound? Yes No

Is the patient **unable** to communicate? Yes No

Implanted devices? Neurostimulators? Yes No

**Breast MRI:**

First day of last period? \_\_\_\_\_

Hormone treatment therapy? \_\_\_\_\_

**ANESTHESIA Patients:**

- Fax OR scheduling sheet to 577-2239.
- Give technologist checklist.
- Remind ordering physician an EKG will be needed for patients over 50.
- H&P must be completed within 24 hrs of MRI
- Notify output floor of exam
  - Adult sedation: 577-7810
  - PEDS sedation: 577-2386
- WIC admits/recent Dr. notes

Wyoming Imaging Center: 307-577-1003

Fax: 307-577-0072