



Lakes Imaging Center

2019 South 6th Street
Brainerd MN 56401
Phone: 877-522-7222
Fax: 218-822-3758

MR# _____
{for office use only}

Patient Information

Date of test: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Work#: _____ Cell#: _____

M ___ F ___ DOB: ___ / ___ / ___ Age: _____ Social Security#: ___ - ___ - ___

Parent name (of minor) or Guardian: _____
(Please print name)

Referring Physician

Name: _____ Clinic: _____

Primary Care Physician

Name: _____ Clinic: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Home #: _____ Work#: _____ Cell#: _____

PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT

The physicians of Northern Orthopedics, Ltd. and Diagnostic Imaging Specialists, P.A.
maintain ownership in Lakes Imaging Center.

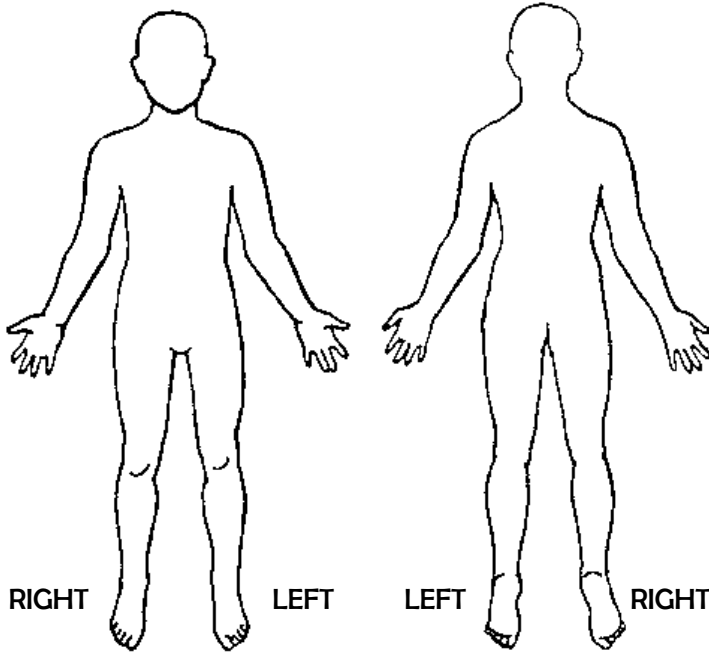


Lakes Imaging Center Open Sided MRI

Patient Name: _____

Date: _____

Please shade in the painful area.



Describe your pain: _____

Injury Date: _____

Allergies: _____

Prior imaging of the area to be scanned: _____

Have you had surgery in the area to be scanned? _____

If yes, when? _____

Type of surgery: _____

Facility where surgery was done: _____

I understand the procedure. The information above is correct and I wish to have the MRI test done.

Patient/Guardian Signature

Date

The following questions will help us determine your safety in the MRI scanner. Please answer each question accurately. Please circle your answer.

Yes	No	Do you have an implantable Bladder Stimulator?
Yes	No	Do you have a Pacemaker or Defibrillator?
Yes	No	Have you had brain aneurysm surgery with surgical clips?
Yes	No	Do you have Cochlear implant(s)?
Yes	No	Have you had a heart valve replaced?

STOP HERE if you answered **YES** to any of the questions above. If **NO** please continue.

Yes	No	Do you wear a neurostimulator unit, Tens?
Yes	No	Do you wear a medication pump or patch?
Yes	No	Do you have a shunt? Date: _____ Place: _____
Yes	No	Have you had brain or head surgery?
Yes	No	Have you had inner ear surgery?
Yes	No	Do you wear an artificial eye?
Yes	No	Have you had eye surgery?
Yes	No	Do you have prosthesis, (i.e. brace, penile)?
Yes	No	Have you had abdominal aneurysm surgery? If YES , what year?
Yes	No	Do you or have you ever had kidney disease, kidney transplant or kidney dialysis?
Yes	No	Do you have Bravo or M2A endoscopy device? If YES , was it done within the last 30 days?
Yes	No	Do you have any metal in your body? Where: _____
Yes	No	Do you have a war or gunshot injury? Location of injury: _____
Yes	No	Have you ever done any welding or metal grinding?
Yes	No	Are you pregnant? Due date: _____
Yes	No	Do you have an IUD? Type of device: _____ Date of insertion: _____
Yes	No	Do you wear hearing aids?
Yes	No	Do you wear dentures or braces?
Yes	No	Do you have a history of seizures?
Yes	No	Do you have diabetes?
Yes	No	Are you claustrophobic?
Yes	No	Do you have a history of cancer? Type: _____

Technician Signature

Date