OPEN MRI OF LONG BEACH	*Patient Name:*	
	DOB:	*Date:*
	Account:	*Accession*:

Please Remove hearing aids, jewelry, watches, wallets and loose metal in pockets!

Medical History	**Yes**	**No**	**Medical History(cont)**	**Yes**	**No**
Have you had an MRI exam before at any location, hospital, or facility in the past?			Have you had any cardiac OR cranial surgery?		
REMOVABLE Hearing aids OR Cochlear implants			Body piercings/custom jewelry?		
Cardiac Pacemaker, Valve Replacement OR Aneurysm clip(s)			Have you had any history of cancer?		
ANY surgical / metal implants or foreign objects in the body (i.e. bullet fragments, IUD, etc)?			Sheet metal worker or Welder ?		
Any External Medication Patches/Pumps/ Monitors (i.e. blood pressure monitor, dialysis pumps, etc)?			Are you claustrophobic?		

USE SECTION FOR MRI WITH CONTRAST ONLY

Chronic Kidney Disease (If NO Skip remaining section)	Yes ❑	No ❑	Allergic to MRI Contrast (If Yes obtain consent)	Yes ❑	No ❑
eGFR (If < 30 obtain Consent)	_____mL/min/1.73 m^2				
Signed Patient Consent	Yes ❑	No ❑			

For Staff Use Only

Weight: ____ lbs

_____ _____ _____

Patient's Signature Date Technologist's Signature