

Prescreening Questions

Patient Name: _____ Date: _____

Yes No Claustrophobic? Sedation: _____

Yes No Active asthma? Date prep kit given: _____

Yes No Are you now or have you ever worked with metal cutting, grinding or welding? _____

Yes No Do you now or have you ever had any metal foreign bodies in you or removed from you? (Example: Bullets, BB's or metal splinters.) _____

Yes No Orbitals scheduled? Date: _____ Facility: _____

Yes No Previous Surgeries: _____

Yes No Implants, clips, valves, stimulator devices or dermal patches: _____

Yes No Pregnant? Last menstrual period: _____

Yes No Breast Feeding?

Yes No Outside films available? _____

Yes No Follow up appointment set? Date: _____

Patient Signature: _____ Date: _____

Consent to Use and Disclose Protected Health Information for Purposes of Treatment, Payment and Health Care Operations

As a patient of Corporate Woods Open MRI, I give consent for my medical information about me (protected health information) to be used or disclosed for purposes of treatment, payment and healthcare operations. I further understand that the privacy regulations allow Corporate Woods Open MRI to use or disclose my medical information for these purposes and that my consent is not required. Corporate Woods Open MRI is obtaining my consent to provide additional assurance regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that Corporate Woods Open MRI may choose not to agree to the request for the restriction on the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

To make a request to revoke my consent I must complete and sign a "Request to Restrict Uses and Disclosures of Protected Health Information" form and return it to our Privacy Officer. I may obtain a copy of the form from our Privacy Officer at Corporate Woods Open MRI, 555 Corporate Woods Parkway, Vernon Hills, Illinois 60061.

Signature of Patient or Personal Representative

Date

Print name of Patient or Personal Representative

Description of Personal Representative's authority to act on Patient's behalf

Patient Name: _____

Date of Birth: _____

Referring MD: _____

Date of Service: _____

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to Corporate Woods Open MRI for any services provided by Corporate Woods Open MRI. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Signature: _____ Date: _____
(Patient)

Private Insurance Authorization for Assignment of Benefits/Information Release

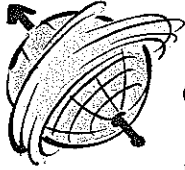
I hereby authorize and request any insurance benefits due me be paid directly to CORPORATE WOODS OPEN MRI for services rendered and acknowledge that I am financially responsible for any unpaid balance. I further authorize CORPORATE WOODS OPEN MRI to release any information acquired in the course of my examination for further medical purposes.

My insurance is a contract between my employer, the insurance company and myself. As such our relationship is with me, not my insurance company, while the filing of insurance claims is a courtesy that CORPORATE WOODS OPEN MRI has extended to me, all charges are my responsibility from the date the services are rendered.

I further agree to pay all the fees and costs incurred in the collection of this account, including but not limited to reasonable attorney fees.

The following signature authorizes the release of information and acknowledges that a photo static copy of this authorization will be valid as the original.

Signature: _____ Date: _____
(Patient, Guardian or Insured)



**CORPORATE WOODS
OPEN MRI**

555 CORPORATE WOODS PARKWAY
VERNON HILLS, IL 60061-3111
PHONE: 847.883.0308
FAX: 847.883.0318
TOLL FREE: 888.440.0308

ANKLE / FOOT EXAMINATION

Patient Name _____

Referring Dr. _____

Exam Date _____

Type of Exam: LEFT or RIGHT Foot or Ankle

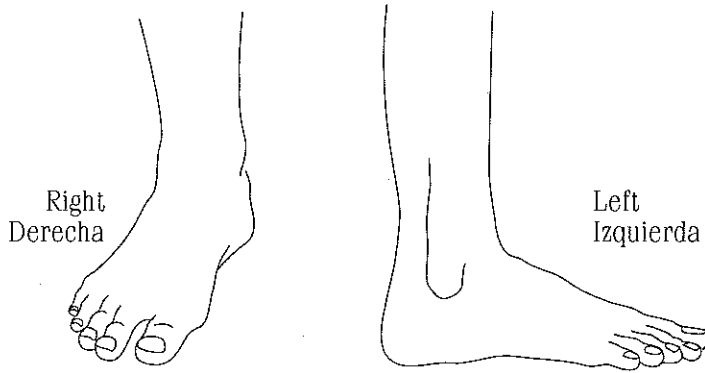
Patient Weight _____ Height _____

Age _____ Sex _____

Please note type of symptom you are having on the pictures below, using the following codes:

Por favor anote el tipo de sintomas que esta padeciendo en los dibujos abajo ilustrados:

P = Pain T = Tingling N = Numbness A = All
D = Dolor C = Cosquilleo A = Adormecimiento T = Todos



How long have you had this problem?
Desde hace cuándo que tiene este problema?

Please summarize any previous history concerning this injury or problem:
Por favor summarize cualquier historia pasada concerniente a esta lesión o problema:

Have you had any surgery or treatment of your foot/ankle? If yes, where and when:
Le han hecho alguna operación o tratamiento de su pie/tobillo? Si la ha tenido, dónde y cuándo?

Have you had any x-rays taken of your foot/ankle? If so, where and when:
Le han tomado radiografías de su pie/tobillo? Si contesto si, dónde y cuándo?

Is this condition the result of an accident or sports injury? If yes, explain:
Los resultados de esta condición son a causa de algún accidente o alguna lesión deportiva? Si contesto si, por favor explique:

Are you a diabetic? _____ Does your foot/ankle swell? _____ Does your foot/ankle give out? _____
Es diabético (a)? Se le hincha su pie/tobillo? Se le vence su pie/tobillo?

Do you have a clicking sound in your ankle? _____ Are you seeing a podiatrist? _____
Le truena su tobillo? Esta viendo a algun especialista en pies?

PATIENT SIGNATURE
FIRMA DEL PACIENTE

DATE
FECHA



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BRAIN EXAMINATION

Patient Name _____

Referring Dr. _____

Exam Date _____

Patient: Weight _____ Height _____

Age _____ Sex _____

What are your present symptoms?
Cuales son sus sintomas presentes?

When do symptoms begin?
Cuando empezaron sus sintomas?

Are the symptoms the result of an accident? If yes, what was the date of the accident?
Son sus sintomas a causa de algún accidente? Si lo son, cuándo se accidentó?

Please circle any symptoms you currently have or previously had and tell us how often.
Por favor circule cualquier sintoma que este teniendo ahora o que haya tenido y qué tan menudo lo (s) tiene.

	Right <i>Derecha</i>	Left <i>Izquierda</i>	Frequency
Weakness <i>Debilidad</i>	_____	_____	_____
Seizures <i>Ataques</i>	_____	_____	_____
Headaches <i>Dolores de Cabeza</i>	_____	_____	_____
Visual Problems <i>Problemas con la vista</i>	_____	_____	_____
Hearing Problems <i>Problemas al oír</i>	_____	_____	_____
Speech Problems <i>Problemas al hablar</i>	_____	_____	_____
Thinking Difficulties <i>Dificultad al pensar</i>	_____	_____	_____
Walking Difficulties <i>Dificultad al caminar</i>	_____	_____	_____
Ringling/Buzzing in Ears <i>Zumbidos o sonidos en los oídos</i>	_____	_____	_____

Have you had a previous CT or MRI of the brain? If yes, when and where?
Le han tomado algún examen de Tomografía o un MRI de su cerebro? Si se lo han hecho, cuándo y dónde?

Comments:
Comentarios:

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KNEE EXAMINATION

Patient Name _____

Referring Dr. _____

Exam Date _____

Type of Exam: LEFT or RIGHT

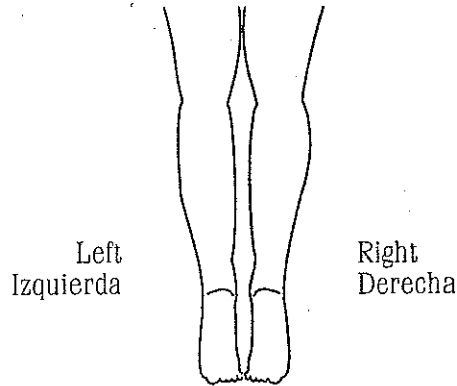
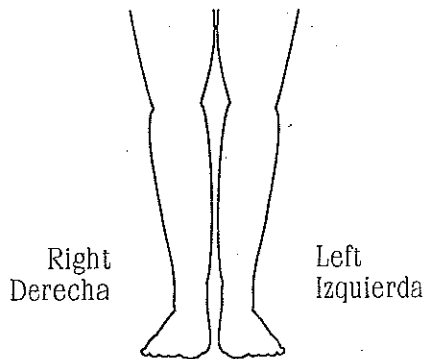
Patient Weight _____ Height _____

Age _____ Sex _____

Please note type of symptom you are having on the pictures below, using the following codes:

Por favor anote el tipo de sintomas que esta padeciendo en los dibujos abajo ilustrados, use los siguientes codigos:

P = Pain T = Tingling N = Numbness A = All
D = Dolor C = Cosquilleo A = Adormecimiento T = Todos



How long have you had this problem?
Desde hace cuánto que tiene este problema?

Please summarize any previous history concerning this injury or problem:
Por favor haga un breve resumen acerca de cualquier historia previa concerniente a esta lesión o problema:

Have you had surgery, arthroscopy, or other treatment on your knees? If yes, where and when:
Ha tenido alguna operacion, exámen de artritis o algun otro tratamiento de su rodilla? Si la ha tenido, cuándo y dónde?

Have you had x-rays taken of your knee? If yes, where and when:
Le han sacado radiografias de su rodilla? Si su respuesta es si, cuándo y dónde?

Is this condition the result of an accident or sports injury? If yes, explain:
Es esta condición a causa de un accidente o se lastimó haciendo deporte? Por favor explique:

Does your knee(s) swell? If yes, Right or Left
Su rodilla (s) se hincha? Si contesto si, cuál? Derecha o Izquierda?

Does your knee(s) give out? If yes, Right or Left
Su rodilla(s) se debilita? Si contesto si, cuál? Derecha or Izquierda?

Do you have popping, pain, catching, or locking in your knee(s)? If yes, Right or Left?
Le truena, tiene dolor o se le desloca su rodilla(s)? Si contesto si, cuál? Derecha o Izquierda?

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MUSCULOSKELETAL QUESTIONNAIRE

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Name _____

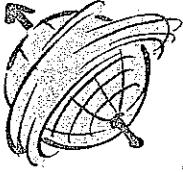
Date _____

Type of MRI _____

1. Have you had any surgery or arthroscopy on the joint being examined today?
 Yes No If yes, when? _____, please explain.
1. *Ha tenido alguna operación o estudio de la coyuntura que se le va a examinar hoy?*
 Si No Si la ha tenido, cuando? _____, explique por favor.
2. Do you have arthritis, kidney disease, vasculitis, parathyroid disease, thyroid disease, cancer, sarcoma, or diabetes?
 Yes No If yes, please explain. _____
2. *Tiene artritis, enfermedad del riñón, inflamación de algún vaso, enfermedad de la Tiroides, cancer, tumores o diabetes?*
 Si No Si tiene algo arriba mencionado, por favor explique. _____
3. Do you take steroids, aspirin, or aspirin-related products?
 Yes No If yes, please explain. _____
3. *Toma esteroides, aspirina, o algún producto con aspirina?*
 Si No Si los toma, por favor explique. _____
4. Have you had any x-rays, CT scans, bone scans, myelograms, or prior MRI's of the area of interest?
 Yes No If yes, please indicate where and when these exams were done.
4. *Le han tomado radiografías, estudios de los huesos, estudios de su espalda o exámenes de MR de la area de interés?*
 Si No Si los ha tenido, por favor indique donde y cuándo se los hicieron.
5. Are there any "clicks", "grinds", "pops", or "locking" in the joint being examined?
 Yes No If yes, please explain. _____
5. *Tiene estallamiento, deslocación, o le truena la coyuntura que se le va a examinar?*
 Si No Si contesto si, por favor explique. _____
6. Have you dislocated the joint before? (i.e. popped the bone out of joint?)
 Yes No If yes, please explain. _____
6. *Se ha deslocado la coyuntura anteriormente? (Se ha safado algun hueso de alguna coyuntura?)*
 Si No Si contesto si, por favor explique. _____
7. Do you have any problems with movement of the joint?
 Yes No If yes, please explain. _____
7. *Tiene algún problema con movimientos de la coyuntura?*
 Si No Si contesto si, por favor explique. _____
8. Is the joint painful? Yes No If so, for how long?
Is any accident, surgery, trauma, or other event related to the pain?
 Yes No If yes, please explain. _____
8. *Le duele la coyuntura* Si No *Si le duele, desde ha cuánto tiempo?*
El dolor es relacionado a un accidente, operación, trauma o algún otro evento?
 Si No Si contesto si, por favor explique. _____
9. When did you first consult the physician who referred you for a MRI?

9. *Cuándo consulto por primera vez al Doctor que lo refino a este Instituto de Resonancia Magnetica?*

Additional Comments:
Comentarios Adicionales:



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SPINE EXAMINATION

Patient Name _____

Referring Dr. _____

Exam Date _____

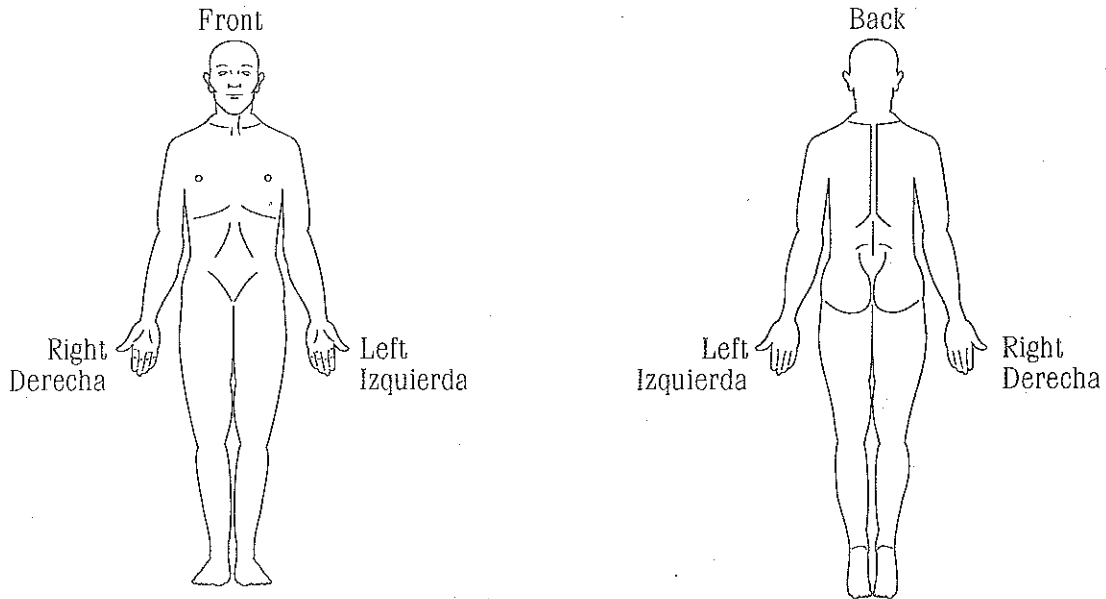
Patient: Weight _____ Height _____

Age _____ Sex _____

Please note type of symptoms you are having on the pictures below, using the following codes:

Por favor anote el tipo de sintomas que esta padeciendo en los dibujos abajo ilustrados, usando los siguientes codigos:

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Have you had any surgery on your neck or back? If yes, when and where and what body part:
Ha tenido alguna operación en su cuello o espalda? Si la tuvo, cuándo, dónde, y en qué parte del cuerpo?

Have you had any other treatment to this body part? Please explain:
Ha tenido algun otro tratamiento en esta parte del cuerpo? Por favor explique:

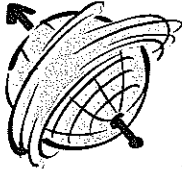
Have you had any fractures of your neck or back? If yes, when and what body part:
Ha tenido algunas fracturas en su cuello o espalda? Si la ha tenido, en que parte del cuerpo?

Are your symptoms the result of an accident? If yes, what was the date?
Los resultados de sus sintomas son a causa de algún accidente? Si los son, en que fecha se accidentó?

Have you had x-rays taken of the affected area? If yes, when and where:
Le han tomado radiografía de la parte afectada? Cuándo y dónde?

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SHOULDER EXAMINATION

Patient Name _____

Referring Dr. _____

Exam Date _____

Patient: Weight _____ Height _____

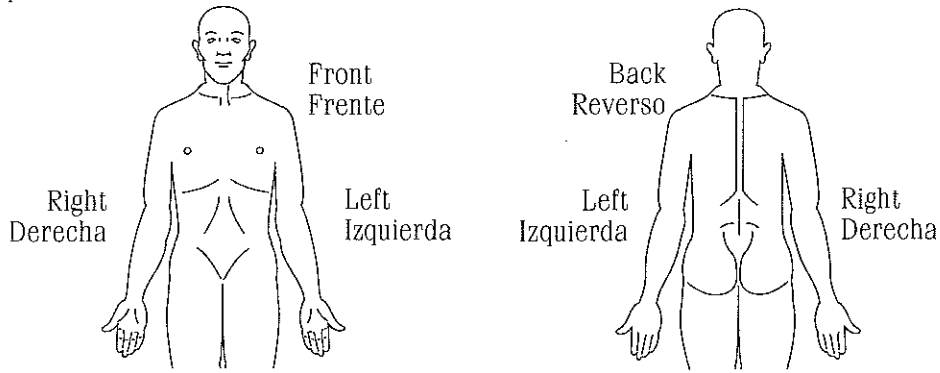
Age _____ Sex _____

How long have you had this problem?
Desde hace cuánto que tiene este problema? _____

Have you ever dislocated your shoulder or had any instability?
Alguna vez se ha deslocado su hombro o ha tenido alguna inestabilidad? _____

Please note type of symptoms you are having on the picture below, using the following codes:
Por favor anote el tipo de síntomas que esta teniendo en los dibujos abajo ilustrados, usando los siguientes codigos:

P = Pain T = Tingling N = Numbness A = All
D = Dolor C = Cosquilleo A = Adormecimiento T = Todos



Have you had surgery or arthroscopy on your shoulder? If yes, where and when:
Ha tenido alguna operación o estudios de artritis en su hombro? Si la tuvo, cuando y dónde?: _____

Have you had x-rays taken of your shoulder? If yes, where and when:
Le han tomado radiografías de su hombro? Si la respuesta es sí, cuándo y dónde?: _____

Is this condition the result of an accident or sports injury? If yes, explain:
Su condición es a causa de algún accidente o lesión deportiva? Si la es, por favor explique?: _____

Do you have trouble picking up objects?
Tiene alguna dificultad recogiendo objetos? _____

Do you have loss of grip strength?
Tiene perdida de fuerza al apretar? _____

Do you have popping, pain, catching or locking in your shoulder?
Tiene estallamiento, dolor o se le desloca su hombro? _____

COMMENTS:
COMENTARIOS: _____


PATIENT SIGNATURE
FIRMA DEL PACIENTE

DATE
FECHA