ST CHARLES IMAGING CENTER

558 St. Charles Drive, Suite 111
Thousand Oaks, CA 91360

MRI Screening Information

Patient Name_____**Date**_____
DOB: _____ **Social Security Number:** _____

Are you claustrophobic? ☐ Yes ☐ No ➔ If Yes, did you take any medication? ☐ Yes ☐ No

Age _____Sex _____ Height _____Weight _____

Referring Physician: _____

Body part to be examined? _____

Please tell us why you are here today and describe any pain or symptoms: _____

_____

When did your pain/symptoms begin? _____

If injured, date of injury? _____

Please list and date any previous related surgeries: _____

_____

Please indicate if you have any of the following:

Diabetes? ☐ Yes ☐ No

History of Renal Disease? ☐ Yes ☐ No

History of Cancer? ☐ Yes ☐ No ➔If Yes, indicate the type of cancer:_____

_____

Please check **all previous** studies **related** to the area that we are scanning today.

OFFICE USE

	Facility	Body Part	Date	CD/Report Here
MRI Scan				
CAT Scan				
NUC MED Scan				
OTHER:				

*****OFFICE USE ONLY *****

TECH _____ TIME OF INJECTION _____ CONTRAST USED/VOLUME _____

SPECIFIC AREA OF INTEREST _____CONTRAST DISCARDED/VOLUME_____

TECH NOTES_____

_____

_____

ST CHARLES
IMAGING CENTER

558 St. Charles Drive, Suite 111
Thousand Oaks, CA 91360

Please indicate if you have any of the following:

Pacemaker	☐ Yes	☐ No	Artificial Heart Valve	☐ Yes	☐ No
Neuro-stimulator	☐ Yes	☐ No	Aneurysm Clips	☐ Yes	☐ No
Biostimulator	☐ Yes	☐ No	Carotid Clips	☐ Yes	☐ No
Infusion Pump	☐ Yes	☐ No	Aortic Clips	☐ Yes	☐ No
Cardiac Defibrillator	☐ Yes	☐ No	Coronary or other Stents	☐ Yes	☐ No
Insulin Pump	☐ Yes	☐ No	Braces (Extremity or spinal)	☐ Yes	☐ No
Heart monitors	☐ Yes	☐ No	Artificial Body Parts	☐ Yes	☐ No
BiPap Breathing Machine	☐ Yes	☐ No	Wigs/Hairpins	☐ Yes	☐ No
Hearing Aids	☐ Yes	☐ No	Medication Patches	☐ Yes	☐ No
Cochlear Implants	☐ Yes	☐ No	Body Piercing	☐ Yes	☐ No
Electrodes	☐ Yes	☐ No	Dentures or Bridges	☐ Yes	☐ No
Pessary to support the Uterus	☐ Yes	☐ No	Braces/Retainers	☐ Yes	☐ No
Tattooed Makeup	☐ Yes	☐ No	Metal in Eye	☐ Yes	☐ No
Are you Breast Feeding	☐ Yes	☐ No	Any Shrapnel	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No	Harrington Rods	☐ Yes	☐ No

Please indicate if you have any other electronic, metal, or foreign body not listed above:

_____

_____

If you answered yes to any of the questions, please indicate the date and where in the body:

_____

_____

<u>*WARNING, STRONG MAGNETIC FIELD***</u>**

<u>Please remove all jewelry, body piercings, and objects prior to your MRI exam.</u>

I attest that the above information is correct to the best of my knowledge. Please inform the technologist if you experience any problem of discomfort during the procedure and the test will be stopped.

_____ _____

Patient or Guardian Signature **Date**

ST CHARLES
IMAGING CENTER

558 St. Charles Drive, Suite 111
Thousand Oaks, CA 91360

Patient Intake Information

Last Name: _____ **First Name:** _____ **Middle Initial:** _____
DOB: _____ **Sex:** _____
Mailing Address: _____
City: _____
State: _____ **Zip-Code:** _____
Primary Contact Number: _____ **Secondary Contact Number:** _____
Emergency Contact: _____ **Phone Number:** _____

GUARANTOR INFORMATION- IF OTHER THAN SELF (If patient is a minor only)

Last Name: _____ **First Name:** _____ **Middle Initial:** _____
DOB: _____ **Sex:** _____ **SS#:** _____ **DL#:** _____
Mailing Address: _____
City: _____
State: _____ **Zip-Code:** _____
Primary Contact Number: _____ **Secondary Contact Number:** _____

INSURANCE INFORMATION

Primary Insurance Provider: _____
Subscriber / Policy Number: _____ **Group Number:** _____
Subscriber Name: _____ Subscriber DOB: _____ Subscriber SS#: _____

Secondary Insurance Provider: _____
Subscriber / Policy Number: _____ **Group Number:** _____
Subscriber Name: _____ Subscriber DOB: _____ Subscriber SS#: _____

Authorization of Benefits and Information Release

I hereby authorize that medical benefit otherwise payable to me for services rendered shall be paid directly to the physician(s) providing care. I hereby authorize St. Charles Imaging Center and my physician to release any information required by my insurance company to process claims.

Signature: _____ **Date:** _____

ST CHARLES IMAGING CENTER

558 St. Charles Drive, Suite 111
Thousand Oaks, CA 91360

Patient Name: _____ **Date:**_____

DOB: _____ **Primary Phone Number:** _____

****

The America Recovery and Reinvestment ACT of 2009 contains the Health Information Technology for Economic and Clinical Heath Act (HITECH). This new regulation requires St. Charles Imaging Center to document your health history and communication preferences in an electronic format. These questions must be asked each time you visit our facilities, regardless of your exam or diagnosis. All information will be kept confidential as required by the Health Insurance Portability and Accountability Act of 1996.

****

What is your race? (Please ✓ One)

☐ White/Caucasian ☐ Black/African American ☐ Hispanic

☐ Asian ☐ Hawaiian/Pacific Islander ☐ Other: _____

☐ Prefer not to answer this question

Do you have a preference in language? (Please ✓ One)

☐ English ☐ Spanish ☐ Chinese ☐ Other: _____

Are you currently taking any medications? ☐ No ☐ Yes ➔ If Yes, attach list or indicate below

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you smoke? ☐ No ☐ Yes ➔ If Yes, how often: ☐ Some Days ☐ Every Day

Do you have any allergies? ☐ No ☐ Yes ➔ **If Yes, what are you allergic to:**

_____

_____

_____ _____

Patient or Guardian Signature Date

558 St. Charles Drive, Suite 111
Thousand Oaks, CA 91360

Missed Appointment Policy

Recently we have been seeing an increase in the number of patients who fail to show up for their scheduled appointments or fail to call the office to cancel their appointment within a reasonable time frame. Every missed appointment jeopardizes the patient/physician relationship and prevents us from providing care to other patients in need of medical care at the time

In an effort to correct that problem, effective March 1, 2020, our office is instituting a policy in which we reserve the right to charge a fee of $50.00 for a missed appointment, or for not calling the office **24 hours** in advance to cancel or change an appointment. This charge is **not billable to the insurance company and it is the patient's responsibility to pay** before another appointment can be scheduled, however, emergency medical care will not be withheld. Not showing for 3 appointments can result in a patient being discharged from the practice, at the physician's discretion.

We regret having to take this actions, but hope that this will improve access to all patients needing care from our physcians.

_____ _____

Patient's Signature Date

_____ _____

Patient's Printed Name **Employee's Signature**

ST CHARLES IMAGING CENTER
558 St. Charles Drive, Suite 111
Thousand Oaks, CA 91360

Magnetic Resonance Imaging Contrast Consent Form

Gadolinium

Gadolinium is an FDA approved contrast agent for MRI. Gadolinium provides greater contrast between normal tissue and abnormal tissue in the body. Gadolinium is a clear non-radioactive liquid, which is administered to you by intravenous injection. After Gadolinium is injected, it accumulates in the abnormal tissue that may be affecting the body.

Gadolinium is used to improve the sensitivity and specificity of your examination. Gadolinium causes these abnormal areas to become very bright (enhanced) on the MRI. This makes it very easy to see. Gadolinium is then rapidly cleared from the body by the kidneys.

In recent medical literature an association has been made between Gadolinium based contrast and patients with moderate to end-stage kidney disease. In the past there have been few serious reactions to this material. The problems encountered have been mild transient headaches, nausea, localized pain at the site of the injection, hives, and rarely a rash. More severe allergic reactions have been reported, but these are extremely rare.

The literature suggest that in very rare instances, patients with moderate to end-stage kidney disease could be at risk for developing Nephrogenic Systemic Fibrosis/Nephrogenic Fibrosing Dermopathy, therefore, the need for gadolinium based contrast should be carefully assessed for those patients.

I authorize and direct Erik Spayde M.D., and/or his associates to administer Gadolinium for MRI scanning. The nature of the injection has been explained to me above.

_____ _____

Patient/Guardian Signature Date

_____ _____

Please Print Name Relationship