



Diagnostic Imaging at Baywalk

MRI HISTORY AND INFORMATION SHEET

Date: _____

Male Female Weight: _____

Exam Ordered: _____

Allergies: _____

Diagnosis: _____

Please describe your symptoms: _____

Have you had any previous surgery? Yes No

If so what kind of surgery? _____

Do you have a history of cancer? Yes No

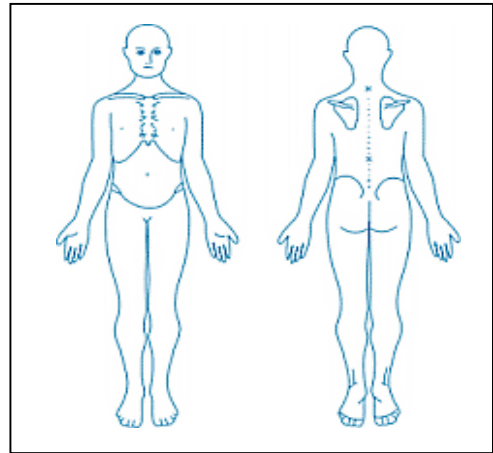
If so what kind of cancer? _____

Have you had previous tests related to todays exam? Yes No

If so what type of exam(s)? MRI CT X-RAY BONE SCAN

Did you bring those films? Yes No

Where were they performed? _____



Please indicate on the picture exactly where you are experiencing pain.

TECHNOLOGIST NOTES: (to be completed by the Technologist)

Indications: _____

CPT Code: _____ ICD-9 Code _____

Contrast injection: Yes No _____ cc's Magnevist.

Protocol: _____
