Cliff Gronseth, M.D.
John Tobey, M.D.
Michelle Pepper, M.D.
Christopher Morelli, D.O.
Vaheed Sevvom, PA-C

SPINE WEST
Physiatry & Sports Physicians

Phone: (303) 494-7773
Fax: (303) 494-1104

**Boulder Office**
5387 Manhattan Circle #200
Boulder, CO 80303

*Trust • Care • Excellence*

**Steamboat Office**
940 Central Park Drive Suite 280
Steamboat Springs, CO 80487

## MRI Screening Form

Last Name: ____________________________ First Name:________________________ MI_____

Birth date: ____/____/____ Sex: M F Patient ID #__________________________________

Address: ________________________________________________________________________

City: ______________________________________State:_________________Zip:______________

Phone: Home: (____)_____-________ Work: (____)_____-________ Mobile: (____)_____-________

Ordering Physician: ____________________________________ Date of MRI: __________________

**** Please answer if you have any of the following:**

| | | |
|---|---|---|
| Cardiac Pacemaker / Cardiac Valve Replacement | Yes | No |
| Brain Aneurysm Clip / Shunt | Yes | No |
| Aortic Clip / Surgical Clips | Yes | No |
| Implanted Neurotransmitter (electronic device) | Yes | No |
| Insulin Pump / Infusion device (internal / external) | Yes | No |
| Hearing Aids (please remove) | Yes | No |
| Cochlear implant / other internal hearing aid | Yes | No |
| Prosthetic device | Yes | No |
| Joint replacements, Metal rods, plates, screws, nails | Yes | No |
| (post op six weeks) | Yes | No |
| Shrapnel, bullet or other foreign body | Yes | No |
| Are you pregnant or trying to get pregnant? IUD? | Yes | No |
| Have you had an eye injury involving metal or do you work with metal occupationally? | Yes | No |
| Tattoos, Eyeliner Tattoos, body piercings | Yes | No |

Have you had any surgeries of the Heart, Brain, Spine or Abdomen? If yes what was done and when?

___________________________________________________________________________________

Have you had an MRI before on this same body part? If yes, at what facility and when was it performed?

___________________________________________________________________________________

**I have read and understand all the above compatibility questions.**

Signature of patient or guardian: _____________________________________________Date: ______________

Signature of person conducting screening: ___________________________________Date: ______________