MUNSTER
MEDICAL IMAGING

Patient Registration

MRI Arthrogram | Please print clearly or fill in on your device

PATIENT INFORMATION

Last name | First name | M.I. | Date of birth (MM/DD/YYYY)

Sex ☐ Male ☐ Female

Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street address

City | State | ZIP code

Cell phone | Home phone | Email

Social Security # | Referring physician

INSURANCE

Primary insurance | Member ID | Group #

Policy holder name | Policy holder date of birth | Relationship to patient

EMERGENCY CONTACT

Name | Relationship | Phone

ASSIGNMENT OF BENEFITS

I hereby authorize my insurance benefits to be paid directly to Munster Medical Imaging. I understand that I am responsible for any charges not covered by my insurance. I also authorize the release of any medical information needed to process my insurance claims.

Patient or guardian signature | Date

MUNSTER MEDICAL IMAGING

Arthrogram Questionnaire

MRI arthrogram | Joint injection followed by MRI

ABOUT YOUR EXAM

Joint being examined

Height

Weight

Side ☐ Left ☐ Right

Please describe your symptoms and how the injury happened

List any surgeries on this joint, with dates

HEALTH QUESTIONS

Are you allergic to contrast (X-ray dye, iodine or MRI contrast)?	☐ Yes	☐ No
Do you have diabetes?	☐ Yes	☐ No
Do you take warfarin (Coumadin) or any other blood thinner?	☐ Yes	☐ No
Are you being treated now for any kind of infection?	☐ Yes	☐ No
Do you have claustrophobia (feel anxious in small, closed spaces)?	☐ Yes	☐ No
Do you have a bleeding disorder or bruise easily?	☐ Yes	☐ No

FOR WOMEN

Are you, or could you be, pregnant?	☐ Yes	☐ No	☐ N/A
Are you breastfeeding?	☐ Yes	☐ No	☐ N/A
Do you use a diaphragm or intrauterine device (IUD)?	☐ Yes	☐ No	☐ N/A

Current medications, including blood thinners

Before your arthrogram

Please call us at 219-513-9035 at least 24 hours before your exam if you need to reschedule, or if you answered yes to any question above. Bring a list of all your medicines. You will meet the doctor and give written consent before the exam begins. Plan to have someone drive you home if you are given anything to help you relax.

Patient or guardian signature

Date

MUNSTER MEDICAL IMAGING

MRI Safety Screening

Required for everyone entering the MRI room

The MRI magnet is always on. Some implants and objects can be hazardous or interfere with your exam, so please answer every question carefully.

Do you have a cardiac pacemaker, pacer wires or an implanted defibrillator?	☐ Yes	☐ No
Do you have any other implanted device (insulin pump, infusion pump, neurostimulator, IUD)?	☐ Yes	☐ No
Do you have a middle-ear or cochlear implant?	☐ Yes	☐ No
Do you have aneurysm clips in the head or neck?	☐ Yes	☐ No
Have you ever had metal particles in your eyes? *If yes and you have not had an MRI since, an X-ray may be needed first.*	☐ Yes	☐ No
Do you have an artificial heart valve?	☐ Yes	☐ No
Do you have an intravascular coil, filter or stent (e.g., IVC filter)?	☐ Yes	☐ No
Do you have shrapnel, bullets or other metal in your body (pins, plates, screws)?	☐ Yes	☐ No
Have you had surgery within the past 6 weeks?	☐ Yes	☐ No
Are you claustrophobic (bothered by small spaces)?	☐ Yes	☐ No
Are you pregnant, possibly pregnant, or breastfeeding?	☐ Yes	☐ No
Do you have body piercings or tattooed eyeliner?	☐ Yes	☐ No
Do you wear dentures, partial plates or hearing aids?	☐ Yes	☐ No
Are you wearing any medicated patches?	☐ Yes	☐ No

If you answered yes to any question, please explain

Before your scan

Hearing aids must be removed before entering the MRI room. Please remove all loose jewelry (earrings, necklaces, watches and bracelets). Depending on your scan, you may be asked to remove dentures or partial plates.

Patient or guardian signature

Date

MUNSTER MEDICAL IMAGING

Contrast Consent

MRI Arthrogram | Consent for contrast media tests and procedures

Patient name

Date of birth

Date

Procedure to be performed

Reason for procedure

PLEASE ANSWER EVERY QUESTION

Are you, or could you be, pregnant? ☐ Yes ☐ No ☐ N/A

If female, first day of last menstrual period

Do you have diabetes, asthma, hay fever, sickle cell disease, myeloma or known thyroid disease? ☐ Yes ☐ No

Are you allergic to any drugs or foods, or have you had a reaction to a previous contrast injection for X-ray, CT or MRI? ☐ Yes ☐ No

Do you take any medications, including non-prescription drugs (for example Glucophage or metformin)? ☐ Yes ☐ No

If yes to any question, please explain

> If you answered yes to any of the questions above, you have a higher than normal risk of an adverse reaction to the contrast used in your exam. Please tell the technologist before your exam begins.

RISKS AND CONSENT

The most common reactions to contrast are mild and pass quickly, such as nausea, vomiting, flushing or a general feeling of warmth. Less often, chills, fever, sweating, headache, dizziness, weakness, wheezing, rash, swelling, cramps or a change in blood pressure may occur, and rarely severe or life-threatening reactions have happened. Contrast may also affect kidney function. These risks have been explained to me, and I understand that the benefit of the exam may outweigh them. I understand I have the right to change my decision or withdraw consent at any time.

I consent to the administration of contrast as my physician or the staff of Munster Medical Imaging consider necessary or appropriate for my exam.

Patient or guardian signature

Date

If signed by a representative, name and relationship to patient

Date

FOR OFFICE USE

Person obtaining consent

Injection site

Contrast used and amount

Patient name

Date of birth

INFORMED CONSENT ARTHROGRAM / JOINT INJECTION / JOINT ASPIRATION

Your clinician can provide you with the necessary information and advice, but as a member of the health care team, you must enter into the decision making process. This form has been designed to acknowledge your acceptance of treatment recommended by your clinician.

Patient: I hereby authorize MUNSTER MEDICAL IMAGING to perform an ARTHROGRAM / JOINT INJECTION / JOINT ASPIRATION.

PROCEDURE: Placement of needle into the joint (shoulder, wrist, hip, knee, elbow or ankle) using x-ray or ultrasound guidance with possible injection of contrast (x-ray dye), local anesthetic or steroid and/or the removal of a small sample of joint fluid.

RISKS: I understand all procedures carry some risk. We (your referring clinician and radiologist) would not recommend this procedure unless we believed all the advantages far outweighed the disadvantages. However, you must understand and accept the potential risks. The potential risks include, but are not limited to: pain, bleeding, infection, joint stiffness, allergic/adverse reaction to injected medications, or temporary anesthesia (numbness or weakness). Rare potential risks include vessel, nerve, or joint injury, weakness, numbness, disability, seizure, arrhythmia and even, death. There is a chance that the needle may not be able to be placed at the desired joint space or result in the desired benefit of pain relief.

BENEFITS: Potential pain relief and/or diagnosis of cause of pain or diagnosis of infection.

ALTERNATIVES TO PROCEDURE: MRI, no procedure, or appropriate medical and/or surgical management. You always have the right to refuse any procedure at any time. It is your responsibility to inform us if you do not want the procedure or wish to stop during the procedure after it has started. It is also your responsibility to inform us of any prior adverse outcome or reaction to a similar study or x-ray dye/anesthetic. I certify that the nature and character of this proposed procedure and the anticipated benefits involved in this proposed procedure have been explained to me. I recognize that during the course of this procedure, post-operative care, medical treatment, anesthesia or other procedure, unforeseen conditions may necessitate additional or different procedures than those set forth. I have been informed that various equipment and instrumentation may be used during my procedure. I, therefore, authorize the above-named physician, and his or her assistants or designees, to perform such procedures as in his or her professional judgement are necessary and desirable. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known to my physician at the time of the medical procedure commenced.

Patient or guardian signature

Date

I certify that this form has been fully explained to me, that I have read it, or have had it read to me, and that I understand its contents.

MUNSTER MEDICAL IMAGING

Privacy Practices Acknowledgment

Health Insurance Portability and Accountability Act (HIPAA)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in my care.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

I acknowledge that I have been offered the Notice of Privacy Practices, and I understand that I may contact Munster Medical Imaging at any time to request a current copy. The Notice is also available at munstermri.com/privacy.html.

I understand that I may request in writing how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations by Munster Medical Imaging.

Patient name (print)

Date of birth

Patient or guardian signature

Date

If signed by a representative, name and relationship to patient