PATIENT INFORMATION FORM

TODAY'S DATE: D / M / Y

PATIENT INFORMATION			
PATIENT'S LAST NAME:	FIRST:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.

SEX:	BIRTH DATE:	NATIONALITY:
❑ Male ❑ Female	D / M / Y	

REPORT

❑ COLLECTING BY HAND

❑ EMAIL: _____

❑ DOCTOR EMAIL:_____

MOBILE NO	HOME PHONE NO.	ADDRESS

OCCUPATION	REFERRING DOCTOR/INSTITUTION

IN CASE OF EMERGENCY

NAME OF RELATIVE OR FRIEND	RELATIONSHIP TO PATIENT:	HOME PHONE NO.:	WORK PHONE NO.:

HOW DID YOU HEAR ABOUT ALEXANDRA MRI?

DIGITAL BILLBOARD ❑ BROCHURES ❑ STATIC BILLBOARD ❑ REFERRED BY DOCTOR ❑

ANOTHER PATIENT ❑ SOCIAL MEDIA ❑ CABLE AND LOCAL TV ❑ OTHER ❑ _____

WHAT MADE YOU CHOOSE OUR FACILITY?

OPEN MRI ❑ REFERRED BY DOCTOR ❑ LOCATION ❑ OTHER ❑ _____

FOR ALEXANDRA MRI USE ONLY

PRINTED IMAGES: ❑ _____ CD: ❑ _____

EMAILED TO PATIENT: ❑ _____ WHATSAPP ❑ _____

EMAILED TO DOCTOR ❑ _____

REPORTING RADIOLOGIST: _____

ADDITIONAL NOTE:

❑CASH ❑CREDIT CARD

❑LINX ❑CHQ # _____

❑PRECERTIFICATION

_____

NOTES:

PLEASE TURN OVER TO COMPLETE QUESTIONAIRE

MRI PATIENT SAFETY QUESTIONNAIRE

Please answer the following Question

QUESTION		YES	NO	DETAILS
DO YOU HAVE, OR HAVE YOU EVER HAD:				
Previous MRI?				
Pacemaker Fitted?				
Heart Surgery or Heart Valve Replacement?				
Operations to your Eyes, Ears, Head or Spine?				
Brain Hemorrhage?				
Aneurysm Clip?				
Cardiac Stents implanted in your Heart?				
Artificial Implanted Devices? Including: artificial joints, limbs, pins, plates, stents, filters, hydrocephalus shunts, eye implants, coils.				
Any Metal Injury to your Eyes? When?				
Skin Patch / Tattoos?				
Dentures, Hearing Aids, Wig?				
Allergic Reaction to Anything?				
Any Kidney Problems?				
Female Patients	Pregnant or suspect to be?			
	Are you breast feeding?			
What is your Weight?				
When last did you eat? Time:		When last did you Drink ? Time:		

For ALL Patients

You will need to REMOVE <u>ALL</u> Metallic Objects

<u>e.g. watch, jewellery, piercings, hairpins, fire arm, credit cards and coins.</u>

Please remove <u>ALL</u> items from your pockets.

I CONFIRM ALL THE ABOVE INFORMATION I HAVE GIVEN IS CORRECT

PATIENT SIGNATURE: _____ Date: _____

ON BEHALF OF PATIENT: _____ Date: _____

RADIOGRAPHER SIGNATURE: _____ Date: _____

THANK YOU FOR CHOOSING ALEXANDRA MRI