FIRSTSCAN™ MRI

Accurate. Affordable. ANSWERS.

Patient Demographics

(please print)

Patient Name (Last, First, MI)		
Date of Birth:	Age:	Sex: □ M □ F
Home Phone:		Email:
Street Address:		
City:	State:	Zip Code:
How did you hear about us?		

Occupation:	Employer:	Employer Address:	Employer Phone:

In Case of Emergency

Name of Local Friend or Relative (not living at the same address:		
Relationship to the patient:	Home Phone:	Work Phone:

The above information is true and correct to the best of my knowledge. I authorize my insurance benefits to be paid directly to FirstScan. I understand that I am financially responsible for any balance. I also authorize FirstScan or my insurance company to release any information required to process my claims.

Patient/Guardian Signature:_____ Date:_____

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Consent for Treatment

I understand that by signing, I consent to have FirstScan provide diagnostic procedure(s) that my referring physician in his/her professional judgment deems medically necessary to diagnose a medical condition(s).

Patient Name:_____ Date:____/____/____

I consent to the use or disclosure of my Protected Health Information (PHI) by FirstScan for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, and to conduct the healthcare operations of FirstScan.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or the healthcare operations of FirstScan. FirstScan is not required to agree to the restrictions that I may request. However, if FirstScan agrees to a restriction that I request, the restriction is binding on FirstScan.

I have the right to revoke this consent, in writing, at any time, except to the extent that FirstScan has taken action in reliance on this consent.

FirstScan, in accordance with this Notice, and without asking for consent or authorization, may use and disclose my Protected Health Information (PHI) for the purposes of:

Treatment—FirstScan may use and disclose my PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan, and manage my healthcare.

Payment—FirstScan may use and disclose my PHI so they may get paid for the services provided to me. FirstScan may provide my PHI directly to a third party who may be responsible for my care, including insurance companies and health plans.

My Protected Health Information means health information, including my demographic information collected from me and create or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review FirstScan's Notice of Privacy Practices prior to signing this document. This notice has been offered to me in the reception area and is also posted on their website at www.firstscanomaha.com and describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills, or in the performance of the health care operations at FirstScan. This Notice of Privacy also describes my rights and FirstScan's duties with respect to my protected health information. If I have any questions, I may contact FirstScan's HIPPA Compliance Officer.

Signature of Patient:_____ Date:____/____/____

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Authorization to Release Medical Records

Name of Patient:_____ Date of Service:____/____/____

Date of Birth:____/____/____ SS#:_____-___-_____ Today's Date:____/____/____

I, the undersigned, authorize the release or, or request access to the information specified below from the medical record(s) of the above name patient.

Patient Information Is Needed For:

Continuing Medical Care Military Social Security/Disability

Insurance Personal Use Legal Purposes School

Other:_____

Information To Be Released or Accessed

Radiology Report:____ Images (CD):____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address) to:

_____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include by is not limited to history and diagnoses.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date:____/____/____ Signature:_____

Patient or Legally Authorized Representative

_____

Printed Name of Patient or Legally Authorized Representative

Relationship to Patient:_____

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For Facility Use

Paradigm Chart#:_____

Accession/MRN:_____

Scanner:_____

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Name of Patient:_____ Today's Date:____/____/____

DOB: ____/____/____ Age: _____ Height: _____ Weight: _____

1. Have you had prior surgery or an operation (in your lifetime) of any kind? Yes No
   If yes, please list all:_____

2. Have you had a prior MRI? Yes No
   If yes, list any problems? (eg: claustrophobia)_____

3. Any welding, grinding, etc? Yes No
   If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? Yes No
   If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (BB, bullet, etc.) Yes No
   If yes, please describe: _____

6. Are you allergic to any medication, specifically gadolinium or MR contrast Yes No
   If yes, please describe: _____

7. Are you allergic to latex? Yes No

8. Have you ever had any device implanted (e.g., pacemaker, stent, pump, etc.)? Yes No
   If please, please describe: _____

9. Have you had any previous prostate biopsies, or biopsies within the scan area? Yes No
   If yes, what were the dates of the procedures:_____

WARNING: Certain implants, devices or objects maybe hazardous to you and/or may interfere with the MR procedure, (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR scan room or MR environment if you have any question or concern regarding an implant, device or object. Consult the MRI technologist or radiologist **BEFORE** entering the MR scan room. **The MR system is ALWAYS on.**

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR scan room, you must remove all metallic objects, including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR scan room.

Please indicate if you have any of the following:

Yes	No	Cardiac pacemaker
Yes	No	Implanted cardioverter defibrillator (ICD)
Yes	No	Heart valve prosthesis
Yes	No	Metallic stent, filter or coil
Yes	No	Aneurysm clip(s)
Yes	No	Electronic implant or device
Yes	No	Magnetically activated implant or device
Yes	No	Neurostimulation device
Yes	No	Spinal cord stimulator
Yes	No	Bone growth/bone fusion stimulator
Yes	No	Internal electrodes or wires
Yes	No	Cochlear, otologic or other ear implant
Yes	No	Eyelid spring or wire
Yes	No	Any type of prosthesis (eye, penile, etc.)
Yes	No	Artificial or prosthetic limb
Yes	No	Shunt (spinal or intraventricular)
Yes	No	Wire mesh implant
Yes	No	Tissue expander (e.g., breast)
Yes	No	Surgical staples, clips or metallic sutures
Yes	No	Joint replacement (hip, knee, etc.)
Yes	No	Bone/joint pin, screw, nail, wire, plate, etc.
Yes	No	Insulin or other infusion pump
Yes	No	Implanted drug infusion device
Yes	No	Vascular access port and/or catheter
Yes	No	Swan-Ganz or thermodilution catheter
Yes	No	Medication patch (Nicotine, Nitroglycerin)
Yes	No	Radiation seeds or implants
Yes	No	Body piercing jewelry
Yes	No	Tattoo or permanent makeup
Yes	No	Dentures or partial plates
Yes	No	Hearing aid *(remove before entering MR scan room)*
Yes	No	IUD, diaphragm or pessary

Do you have any of the following conditions:

Yes	No	Heart disease
Yes	No	Diabetes
Yes	No	Hypertension
Yes	No	Multiple Myeloma
Yes	No	Kidney disease/Renal insufficiency
Yes	No	Are you currently on dialysis
Yes	No	Personal History of cancer
Yes	No	Are you currently receiving chemo
Yes	No	Do you have any transplanted organs

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: ____/____/____

Signature

Form Completed By: ___Patient ___Relative ___Nurse _____

Print Name/Relationship

Signature of Technologist Reviewing Form: _____ Date: ____/____/____

Signature

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Acknowledgement of Receipt Of Notice Of Privacy Practices

I acknowledge that I have received FirstScan's Notice or Privacy Practices, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

_____ Date:____/____/____

Signature

_____

Printed Name

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Prostate Questionnaire

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Date of Birth: _____

Referring Physician: _____

1. What is your serum PSA? Date(s) _____

2. What are your urine PCA3 results? Date(s) _____

3. Have you had a Transrectal Ultrasound Guided Biopsy (TRUS)? If so, when? _____

   What were the biopsy results? _____

4. Do you have a history of prostatitis? If so, have you been treated with antibiotics? _____

5. If you have prostate cancer:

   a. What is your Gleason score? _____

   b. Have you had a prostate MRI? If so, when? _____

   c. Have you had staging imaging including CT Abdomen/Pelvis or nuclear medicine bone scan? _____

   d. Has your prostate cancer been treated?

      1. Surgery? Yes ☐ No ☐ _____

      2. Radiation therapy? Yes ☐ No ☐ Type? _____

      3. Hormone therapy? Yes ☐ No ☐ _____

      4. Other _____

6. Do you take any medications for your prostate? If so what?

_____ _____

Name of Medication/ Strength/How Many Times Per Day *Name of Medication/ Strength/How Many Times Per Day*

_____ _____

Name of Medication/ Strength/How Many Times Per Day *Name of Medication/ Strength/How Many Times Per Day*

7. Are you being treated with Testosterone? Yes ☐ No ☐

8. Have you had surgery for BPH (Benign Prostatic Hyperplasia)?

a. TURP? _____Date(s) _____ b. Laser? _____Date(s) _____

9. Do you have a family history of Prostate Cancer? If so, whom?_____

Patient Signature: _____ Date: _____