CBJD
THE CENTER FOR BONE & JOINT DISEASE

PATIENTS NAME _____ DATE OF BIRTH _____

ADVANCE NOTICE TO MRI PATIENTS

BODY PART: _____ DATE: _____

PLEASE BE AWARE THAT RADIOLOGY ASSOCIATES WILL BE READING YOUR MRI.
RADIOLOGY ASSOCIATES WILL BILL YOUR INSURANCE FOR THE RADIOLOGIST READ.

PATIENTS SIGNATURE _____ DATE _____

10221 Yale Avenue., Brooksville, FL 34613 • (352) 596-0900 • Fax (352) 596-0440
7544 Jacque Road, Hudson, FL 34667 • (727) 697-2200 • Fax (727) 863-8774

NOTIFICATION OF REFERRAL

Dear Patient,

Effective March 23, 2010, Section 6000.3 of the Patient Protection and Affordable Healthcare Act was signed into law. The new law requires providers to supply written notification to the patient of other facilities that provide the same services in the area where the patient resides, when ordering Designated Health Services (DHS) as designated by the Health and Human Services secretary. The services you need are considered to be DHS. In compliance with the Act, we are providing a list of suppliers who furnish such services in the area in which you reside.

Our office provides these services with high quality equipment, well qualified technicians and the interpretations for the physicians are expedited to provide the best patient care. We also have your clinical information to better correlate the studies. We provide these services as a convenience to you so that you can have these services performed at the same location where you receive your medical services and we can obtain quicker results to follow up with you in a timely manner.

If you prefer to have these tests performed at another facility other than our office, it will be your responsibility to check with your insurance company for their list of participating facilities.

By signing the form, you acknowledge that you have received the appropriate notification for DHS referrals.

Patient Signature _____ Date _____

New Port Richey:
Radiology Associates
5539 Marine Pkwy
727-847-5122

Florida Institute for Advanced Imaging
9238 US Hwy 19
727-849-8492

Hudson:
Pasco Imaging
7615 Jacque Rd
727-697-0100

Bayonet Point Hospital
14000 Fivay Rd
800-921-7155

Spring Hill:
West Hernando Diagnostic Center
3315 Commercial Way
352-688-5860

Spring Hill MRI
6451 Toucan Trail
352-684-2811

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PATIENT NAME: _____

Magnetic Resonance Imaging (M.R.I.) is an extremely sensitive medical technique that requires images to aide your physician in your diagnosis. In an M.R.I. radio waves and a magnetic field are used. There are no x-rays, so for your safety it is very important to answer the following questions.

	Yes	No
Do you have kidney insufficiency?	_____	_____
Are you presently on dialysis?	_____	_____
Do you have liver insufficiency?	_____	_____
Do you have a cardiac pacemaker?	_____	_____
Have you ever had heart surgery?	_____	_____
Have you had a valve replaced in your heart?	_____	_____
Do you have intracranial clips?	_____	_____
Have you ever had brain surgery?	_____	_____
Have you had surgery on your eyes?	_____	_____
Have you ever had surgery on your inner ear?	_____	_____
Have you ever had an aneurysm surgery?	_____	_____
Have you ever been a welder or sheet metal worker?	_____	_____
Have you had to have metal removed from your eyes?	_____	_____
Have you ever had shrapnel injuries?	_____	_____
Do you have an implanted TENS unit?	_____	_____
Are you wearing removable dental work?	_____	_____
Are you pregnant?	_____	_____
Do you have an IUD?	_____	_____
Do you have any metal rods, plates, pins, screws or staples in your body from surgery?	_____	_____

	Yes	No
Do you have an insulin or morphine pump?		
If yes, what kind?		
Do you have body piercing?		
Do you have tattoo eyeliner?		
Do you wear hearing aids?		
Have you had a prior MRI of the same body part being scanned today?		
If yes, where _____ , when _____		

Approximate Height and Weight: _____

Date of Birth: _____

Are you taking any medication? Yes _____ No _____

Please describe your symptoms specifically in the area that will be scanned / tested.

_____

_____

Is your condition the result of an injury? (If yes, please describe and give the date)

_____

_____

Have you ever been diagnosed with cancer? _____

Please list all surgeries and list the year they were done. _____

_____

By signing this form, you indicate that you understand these forms and are consenting to be scanned.

_____ _____

Patient or Guardian Signature *Date*