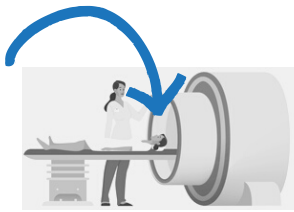


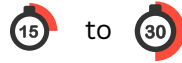


Step 1: Read

Magnetic Resonance Imaging (MRI) gives your doctor a great view of your body. Non-Invasive! NO RADIATION.



The actual scan takes approx. this much time



Step 1: Get MRI*

You'll come to OSS and work with our licensed radiological technologist. **An MRI is SAFE; it has no radiation.** It uses magnetic field energy to take the images of your body's structure; the benefit is the doctor is able to better determine what's the true condition of the bones, the soft tissues, and muscles.

Since the magnet in the MRI is very strong and attracts any metal objects taken into the room, you'll need to follow our safety rules and precautions.

- On the day of, you will review the safety questions again with our team to make sure nothing on or in your body will interfere with your safety.
- You will follow the precautions before you enter the MRI room.

Once in the MRI room, you'll lay on a table that slides you into the MRI. The technician will take the images. Your job is to stay very still so the images do not get blurry.

After the images are taken, our trusted board-certified radiology partners will review the image(s) and give the official MRI reading to OSS within 3 days.



You **MUST CANCEL** the **MRI appointment** if you:

- Just had an injury with metal since your last appointment at OSS
- Had an endoscopy **WITHIN** the last 7 days

Step 2:

Follow Up with OSS Doctor

In about a week, you'll meet with your OSS doctor, either virtually (telehealth) or in person (at our office). During this visit, the OSS doctor explains the radiologists' findings and gives a treatment plan.

Step 2. Fill out MRI Safety / Consent form + Follow Checklist

Before Imaging Appointment

- Complete [MRI Safety / Consent Form](#) (either get at ossburbank.com or at OSS office).
- Complete [other forms](#), if instructed. If minor or for support, parent / guardian / friend, the visitor must fill out the Visitor MRI Safety / Consent form. If pregnant, getting contrast, and/or accepted implant, you must fill out the specific section on the Additional MRI Safety / Consent form.

Day of imaging:

- **Before you come to the office**, wear clothing that is best for the MRI. Specifically, avoid wearing metal (zipper, buckles, metal clasps) and wear loose clothing. Please do not bring or wear valuable jewelry or items to the appointment. Wedding rings can stay on. Know it's also okay to wear eye contacts.
- Plan on arriving **15 minutes early** to OSS (Our address: 3413 W. Pacific Ave, Suite 100, Burbank, CA 91505).
- Please bring your insurance card, photo ID, and payment (if and as discussed).
- **Once you are checked in at OSS**, you'll hand in the completed MRI Safety / Consent Form and you'll review it with the Imaging Technologist. You'll be asked to remove piercings and any metal you are wearing. (You may be asked to change at our office into a patient gown provided by OSS.) OSS will also give you ear plugs which you must wear to shield your ears from the loud noise MRI machines routinely make.

Bring the MRI SAFETY / CONSENT form to your appointment.



Please complete this required form.

Orthopaedic Surgery Specialists is the registered business official name of OSS.

Patient Name _____ Last _____ First _____ M.I. _____ Date of Exam _____ MM/DD/YYYY _____ Sex _____
 Female Male

Weight lbs Date of Birth MM/DD/YYYY Age Name of the provider who ordered the study? _____

IMPORTANT. Please mark **Yes** or **No** so we can make sure the **MRI DOES NOT INTERFERE** with your **SAFETY**.

Box 1



If you have a **PACEMAKER, DEFIBRILLATOR, ANEURYSM CLIP** or **ANY OTHER IMPLANT LISTED IN THIS BOXED SECTION, DO NOT PROCEED** with your MRI. Tell your doctor so you can discuss next steps.



Do you have any of the following **INSIDE your body?**

	Yes	No		Yes	No
Heart pacemaker (cardiac pace maker including the wires)	<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator for your heart (ICD - cardiac defibrillator)	<input type="checkbox"/>	<input type="checkbox"/>	Device implanted to expand breast (or other) tissue	<input type="checkbox"/>	<input type="checkbox"/>
Pump or device to infuse drugs (pain pump)	<input type="checkbox"/>	<input type="checkbox"/>	Stimulator implanted for bone growth or bone fusion	<input type="checkbox"/>	<input type="checkbox"/>
Implant in the ear (cochlear, otologio)	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis or implant in the eye, penile, etc. (eyelid spring or wire)	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm clip or a shunt implanted because you had brain / spine surgery	<input type="checkbox"/>	<input type="checkbox"/>	Do you work with metal routinely?		
Do you work with metal routinely?	<input type="checkbox"/>	<input type="checkbox"/>	Metal in your eye because of an injury	<input type="checkbox"/>	<input type="checkbox"/>
Metal in your eye because of an injury	<input type="checkbox"/>	<input type="checkbox"/>	Metallic fragment or foreign body (bullet, needle) in your head, face, neck or body	<input type="checkbox"/>	<input type="checkbox"/>
Metallic fragment or foreign body (bullet, needle) in your head, face, neck or body	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of these conditions?		
			A bad reaction to a contrast agent used for MRI, CT or Xray	<input type="checkbox"/>	<input type="checkbox"/>
			Claustrophobia (fear of enclosed spaces) or panic attacks	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply to you:

For **Females:**

Are you pregnant or possibly pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	IVC Filter or venous umbrella to prevent DVT	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	↳ Yes, Card Submitted? <input type="checkbox"/>		
Camera pill because you did an endoscopy	<input type="checkbox"/>	<input type="checkbox"/>	Magnetically activated implant or device	<input type="checkbox"/>	<input type="checkbox"/>
↳ If yes, date of procedure			↳ Yes, Card Submitted? <input type="checkbox"/>		

Section 2
Yes No

Thanks for filling the top half. **Please finish the rest at home.** Please show the top portion **now** to the OSS check out team.

Do you **USE** or **WEAR** a...?

	Yes	No		Yes	No
Any body piercing jewelry (the belly button, nose, ears, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid, dentures, or glasses	<input type="checkbox"/>	<input type="checkbox"/>
Artificial limb (prosthetic)	<input type="checkbox"/>	<input type="checkbox"/>	Medication patch on skin (e.g., nitroglycerin, nicotine)	<input type="checkbox"/>	<input type="checkbox"/>

Section 3
Yes No

Do you have any of the following pieces of metal or ink **ON** or **INSIDE your body?**

	Yes	No		Yes	No
Joint replacement implant in your knee, hip, shoulder, etc (because of joint replacement surgery)	<input type="checkbox"/>	<input type="checkbox"/>	Pessary or bladder ring to decrease urine leakage	<input type="checkbox"/>	<input type="checkbox"/>
Implanted pin, screw, nail, wire, plate, or rod because of orthopaedic surgery	<input type="checkbox"/>	<input type="checkbox"/>	Heart stent or artificial heart valve from a cardiac procedure	<input type="checkbox"/>	<input type="checkbox"/>
Implanted wire mesh, staples, clips or metallic sutures because of a surgery or procedure	<input type="checkbox"/>	<input type="checkbox"/>	Vascular access port or catheter	<input type="checkbox"/>	<input type="checkbox"/>
IUD (intrauterine) device or diaphragm for birth control	<input type="checkbox"/>	<input type="checkbox"/>	Dental implant(s) (plate)	<input type="checkbox"/>	<input type="checkbox"/>
			Tattoo or tattooed make up	<input type="checkbox"/>	<input type="checkbox"/>

Section 4
Yes No



Please complete this required form.

Orthopaedic Surgery Specialists is the registered business official name of OSS.

This section shows your acknowledgement and consent of the the MRI safety rules at OSS Imaging.

Please initial below.

I will **change into a gown**, if directed. I may be able to stay in my street clothes if I am wearing no metal. The OSS technologist will tell me.

I will **wear ear protection (ear plugs)**. During the MRI, I will wear hearing protection (ear plugs) because the machine will make loud noises.

I will **remove all metal** before I enter the MRI room. I will not enter the MRI room if I have any questions or concerns regarding an implant device or object. I have answered and reviewed the MRI Safety / Consent form with OSS.

- ↳ **I MUST remove:** Hearing aid, dentures, partial plates, eyeglasses, artificial limb, medication patch, TENS unit, jewelry, brace or bra with underwire or wire clip.
- ↳ **I must lock up my personal belongings into the OSS dressing room locker.** Keys, pager, cell phone, hairpins, barrettes, jewelry, watch, safety pins, body piercing jewelry, money clip, credit card, magnetic strip cards, coins, paper clips, pens, pencils, paper clips, pens, pocket knife, and/or nail clipper. I also understand that OSS is not responsible for any lost or stolen items.
- ↳ Failure to inform Orthopaedics Surgery Specialists of implants or metals inside of my body may cause serious bodily injury or be life threatening. By proceeding with the MRI after discussing metal (possible or confirmed) in your body with the ordering physician and /or MRI Technologist, I agree to release Orthopaedics Surgery Specialists from any and all liability for any injury. Certain implants, devices or objects may be hazardous to you and/or may interfere with the MR procedure. Consult the Imaging Tech team before entering the MR system room. The MR System magnet is always on.

I understand the **possibility of Skin Warming**. MRI Radio-frequency has the potential to cause tissue heating. I will alert the technologist immediately if I notice any heating sensation during my MRI scan. Here are some of the precautions I must take: 1. I understand that it is important for me to keep as still as possible in the MRI. 2. I will not cross my hands or feet to avoid skin touching skin.

Patient Consent.

By signing this consent, I agree that I have read this form and/or I have received oral communications of all the information provided in this form. I understand the information, and have had my questions answered regarding this procedure and who will read the exam. In addition, I agree that I 1) understand the purpose of the procedure; 2) have been informed of how long the procedure will take; 3) understand the risks, benefits, and complications associated with the procedure; 4) have truthfully informed Orthopaedic Surgery Specialists (OSS) Imaging of my current medical condition 5) am aware of possible alternatives; and 6) have been given the right to refuse to consent to the procedure.

I have not been pressured to sign this consent and do so voluntarily. I understand that I may contact OSS at the address and phone number provided if I have any further questions about this form or the procedure. I am at least 18 years of age, of sound mind and not under the influence of alcohol or hallucinogenic drugs. I have no reservations and give my consent to start and complete the exam(s) by my signature and date here.

Patient Name: _____
 Print Signature + Date

OSS Imaging Team Member (Witness): _____
 Print Signature + Date

Technologist Notes: _____