Stockton Diagnostic Imaging
1801 E March Lane, Suite A-130
Stockton, CA 95210

Date: 11-08-2018

ANDERSON, TIFFANY
13966064 **Preferred Language: English**
Sex: Female **Age: 48 y** **DOB: 08-22-1970**

Examination Form

Patient Name: ANDERSON, TIFFANY **Phone:** (209) 331-0208

DOB: 08-22-1970 **Sex:** Female **MRN:** **13966064** Spec. Accommodations: N

Accession: 16571186 **Exam: MR Abdomen WO [74181] - Abdomen**

Room: OST - MR1 **On:** 11-09-2018 3:30:00 PM **Duration:** 45 minutes

History: 08-30-2018 8:00 AM US Abdomen Complete [76700] - Abdomen

Signs/Symptoms: WIDESPREAD MUSCULOSKELETAL ISSUES

Comments:

11-08-18 jreyes - RIF, AUTH, PT CONF
11-01-18 mfarias - NEW AUTH SCANNED
10-29-18 jreyes - RIF, AUTH, LMOR TO CONFIRM, ADV OF PREP
10-18-18 lclem - (AUTH)
10-17-18 mfarias - FAXING NEW AUTH 04:16 PM PREP GIVEN
10-17-18 mfarias - JENNIFER AT OCM RESCHED APPT
09-05-18 lclem - PT N/S
08-31-18 jreyes - RIF, AUTH, CONFIRMED
08-28-18 jreyes - RIF, AUTH, PT CONF
08-20-18 ajohnson - WT 140 HT 5.2 P-N S-N M-N C-N PT CLEARED SCHEDULED W/ JEFF AT OCM, HE WILL FAX AUTH

Patient Allergies:

No known allergies.

Requesting MD: MICHAEL M BRONSHVAG, MD

Provider Notes:

Requesting Address

11010 WHITE ROCK RD STE 120
RANCHO CORDOVA, CA 95670
Requesting Phone: (800) 458-1261
Requesting Fax: (916) 920-2515

CC Physicians: BROKER, ONE CALL CARE DIAGNOSTICS

Accession: 16571186

Guarantor Information: Self

Primary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO If Yes, whom?

Primary Insurance Name: ONE CALL CARE DIAGNOSTICS Plan Name:

Address: **20 WATERVIEW BLVD**

City: **PARSIPPANY** State: **NJ** Zip: **07054**

Policy #: **OCMP02379800** Group #: DOB: **08-22-1970**

Policy Holder Name: **ANDERSON, TIFFANY** Sex: **female**

Policy Holder Address:

City: State: Zip:

Patient's Relationship to Policy Holder: **Self**

STOCKTON DIAGNOSTIC IMAGING™

Stockton Diagnostic Imaging
1801 E March Lane, Suite A-130
Stockton, CA 95210
Phone: (209) 475-9871
Fax: (209) 474-9620

PATIENT INFORMATION FORM

Last Name: **ANDERSON** First Name: **TIFFANY** Middle Name:

MRN: **13966064** DOB: **08-22-1970** Gender: **F**

Address 1: **PO BOX 477**

Address 2:

City: **Lodi** State: **CA** Zip Code: **95241**

Home Phone: **(209) 331-0208** Work Phone: ( ) -

Cell Phone: ( ) - Email: **TIFFANTABDERSIB@ME.COM** ☐ Opt-out of educational/marketing emails

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email ☐ Mail

Preferred Delivery Method: ☐ Mail ☐ Electronic Preferred Language:

Race: ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian / Other Pacific Islander ☐ White / Caucasian

Are you: ☐ Hispanic ☐ Not Hispanic Referring Physician: **MICHAEL BRONSHVAG, MD**

RESPONSIBLE PARTY INFORMATION

Last Name: **ANDERSON** First Name: **TIFFANY**

Patient's Relationship to Responsible Party: **Self** Phone: **(209) 331-0208**

Address 1: **PO BOX 477**

Address 2:

City: **Lodi** State: **CA** Zip Code: **95241**

Primary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO If Yes, whom?

Primary Insurance Name: **ONE CALL CARE DIAGNOSTICS** Plan Name:

Policy #: **OCMP02379800** Group #:

Policy Holder Name: **ANDERSON, TIFFANY** Sex: **female**

Patient's Relationship to Policy Holder: **Self** DOB: **8/22/1970**

Secondary Insurance Information

For Medicare Patients: Are You or Your Spouse Working?: ☐ YES ☐ NO If Yes, whom?

Primary Insurance Name: Plan Name:

Policy #: Group #:

Policy Holder Name: Sex:

Patient's Relationship to Policy Holder: DOB:

MEDICAL INFORMATION

Is this visit related to an auto accident? ☐ Yes ☒ No

Is this visit related to an injury sustained while at work? ☒ Yes ☐ No

Date of Injury: 2 | 04 / 19 / 04 906/29/11 Height: 5 ft. 4 in. Weight: 150

SMOKING STATUS:

☐ Current Every Day ☐ Current Some Days ☒ ~~Never~~ smoked ☐ Smoker, current status unknown ☐ Former smoker ☐ Unknown

ACTIVE MEDICATIONS: ☒ None

☐ ActoPlus Met	☐ Fortamet	☐ Glyburide-metformin	☐ Jentadueto	☐ Metformin
☐ Avandamet	☐ Glucophage	☐ Glycomet	☐ Kazano	☐ PrandiMet
☐ Diabex	☐ Glucovance	☐ Invokamet	☐ Kombiglyze XR	☐ Riomet (liquid form of Metformin)
☐ Diafomin	☐ Glumetza	☐ Janumet	☐ Metaglip	☐ Xigduo

MEDICAL HISTORY: ☐ None

☐ Aneurysm Clip / Coil	☐ Breast Implants	☐ Insulin Pump	☐ Paraplegic
☐ Aneurysm **Had Surgery**	☐ Cancer	☐ Metal In the Body	☒ Previous CT Contrast Reaction
☐ Aneurysm **NO Surgery**	☐ Diabetes	☐ Morphine Pump	☒ Previous MR Contrast Reaction
☒ ~~Asthma~~	☒ Hypertension	☐ Pacemaker	☐ Renal Disease

ALLERGIES: ☐ None

☐ Adhesive Tape	☐ Mild	☐ Moderate	☐ Severe	☐ Latex	☐ Mild	☐ Moderate	☐ Severe
☐ Bee Sting	☐ Mild	☐ Moderate	☐ Severe	☐ Lidocaine / Novocaine	☐ Mild	☐ Moderate	☐ Severe
☐ Betadine (Topical Iodine)	☐ Mild	☐ Moderate	☐ Severe	☐ Mold	☐ Mild	☐ Moderate	☐ Severe
☒ Contrast (Med. Imaging)	☐ Mild	☒ Moderate	☐ Severe	☐ Peanut or other nut	☐ Mild	☐ Moderate	☐ Severe
☐ Dog, Cat, or Animal	☐ Mild	☐ Moderate	☐ Severe	☐ Penicillin	☐ Mild	☐ Moderate	☐ Severe
☐ Dust	☐ Mild	☐ Moderate	☐ Severe	☐ Rubbing Alcohol	☐ Mild	☐ Moderate	☐ Severe
☐ Fruit	☐ Mild	☐ Moderate	☐ Severe	☐ Shellfish	☐ Mild	☐ Moderate	☐ Severe
☐ Grass / Pollen	☐ Mild	☐ Moderate	☐ Severe	☐ Sulfa Drug	☐ Mild	☐ Moderate	☐ Severe

Mild allergic reactions include hives, itching, nasal congestion, rash and watery eyes.
Moderate allergic reactions include cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, lightheadedness, flushing/redness of face, nausea, vomiting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconsciousness.
Severe allergic reaction is anaphylactic shock.

TO OUR FEMALE PATIENTS

Some imaging procedures are contra-indicated (not recommended) for patients who may be pregnant. If you may be pregnant, please notify one of our team members. By my signature below, I acknowledge that I have read and understand this statement and state that I am not pregnant and there is no chance that I may be pregnant.

Signature _____ *Date* 11-9-16

Date of Last Menstrual Period: ___/___/08

AUTHORIZATION & AGREEMENT

I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use, disclose or obtain any of my personal health information for treatment and payment. If I am UNINSURED, I understand I am fully responsible for all charges.

Expenses collected from you at the time of service are an estimated cost of your visit. If, after your insurance is billed, should your policy apply any additional amount to your out of pocket expense, you are personally responsible for that amount and will be billed for that balance then due.

Signature of Patient, or Personal Representative, for TIFFANY ANDERSON _____ *Date* 11-9-16

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1801 E March Lane, Suite A-130
Stockton, CA 95210

MRI PATIENT HISTORY AND CONSENT

Effective Date: 2/1/18

PATIENT DEMOGRAPHICS

Patient's Name: TIFFANY ANDERSON Medical Record: 13966064

Date of Exam: 11/9/18 Referring Dr: MICHAEL BRONSHVAG, MD

DOB: 08-22-1970 Age: 48 y Height: _____ Weight: _____ Sex: F

WARNING: THE MRI SYSTEM MAGNET IS ALWAYS ON

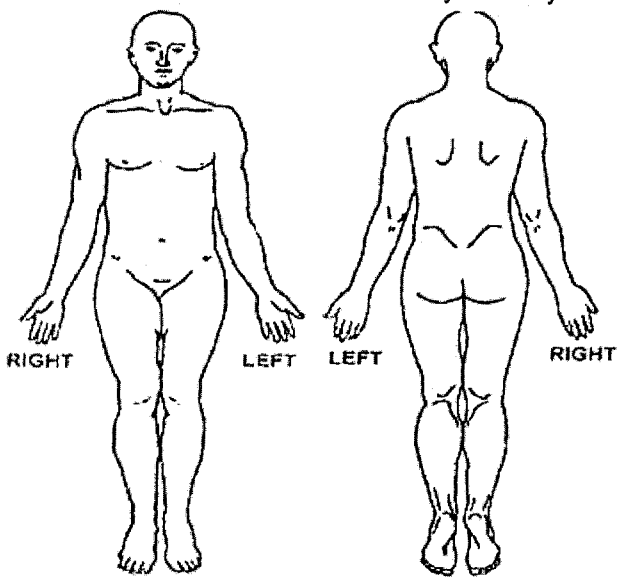
Certain implants, devices or objects may be hazardous and/or may interfere with your MRI procedure.
Do not enter the MRI exam room if you have questions or concerns regarding an implant, device or object.
Consult the MRI Technologist BEFORE entering the MRI exam room.

HAVE ANY OF THE FOLLOWING?

☐ YES	☑ NO	Injury to your eye involving metal
☐ YES	☑ NO	Any metallic fragment or foreign body
☐ YES	☑ NO	Aneurysm clip(s)
☐ YES	☑ NO	Cardiac pacemaker
☐ YES	☑ NO	Implanted cardioverter defibrillator (ICD)
☐ YES	☑ NO	Electronic implant or device
☐ YES	☑ NO	Magnetically-activated implant or device
☐ YES	☑ NO	Neurostimulation system
☐ YES	☑ NO	Spinal cord stimulator
☐ YES	☑ NO	Internal electrodes or wires
☐ YES	☑ NO	Bone growth / bone fusion stimulator
☐ YES	☐ NO	Cochlear, ôtologic or other ear implant
☐ YES	☐ NO	Insulin or other infusion pump
☐ YES	☐ NO	Implanted drug infusion device
☐ YES	☐ NO	Any type of prosthesis (eye, penile, etc.)
☐ YES	☐ NO	Heart valve prosthesis
☐ YES	☐ NO	Eyelid spring or wire
☐ YES	☐ NO	Artificial or prosthetic limb
☐ YES	☐ NO	Metallic stent, filter or coil
☐ YES	☐ NO	Shunt (spinal or intraventricular)
☐ YES	☐ NO	Vascular access port and/or catheter
☐ YES	☐ NO	Vascular access port and/or catheter
☐ YES	☐ NO	Radiation seeds or implants
☐ YES	☐ NO	Swan -Ganz or thermodilution catheter
☐ YES	☐ NO	Medication patch (Nicotine, Nitroglycerine, etc.)
☐ YES	☐ NO	Wire mesh implant
☐ YES	☐ NO	Tissue expander (breast or other)
☐ 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	IUD, diaphragm or pessary
☐ YES	☐ NO	Other implant: _____
☐ YES	☐ NO	Dentures or partial plates
☒ YES	☐ NO	Tattoo or permanent makeup
☐ YES	☐ NO	Body piercing jewelry
☐ YES	☐ NO	Hearing aid (emove before entering exam room)
☒ YES	☐ NO	Breathing problem or motion disorder
☐ YES	☐ NO	Claustrophobia

IMPORTANT INSTRUCTIONS

Mark on the figure below the location of any implant or metal inside of or on your body



Remove ALL metallic objects in the dressing room, including:
- hearing aids
- dentures and partial plates
- cell phone and pagers
- keys
- eyeglasses
- hair pins and barrettes
- jewelry and watch (including body piercing jewelry)
- safety pins
- money clip and coins
- credit cards, bank cards and magnetic strip cards
- pens
- pocket knife
- nail clipper
- steel-toed boots/shoes
- clothing with metal fasteners and metallic threads
- tools
- all loose metallic objects

*** Consult the MRI Technologist if you have any questions or concerns BEFORE you enter the exam.**

Technologist Notes:

***All patients having MRI studies MUST wear hearing protection (ear plugs or ear muffs). No exceptions.**

PREGNANCY and BREASTFEEDING STATUS

*If a mother desires, she may refrain from breastfeeding for 24 hours and discard milk after gadolinium injections.

Are you: **Pregnant?** ☐ YES ☐ NO **Possibly Pregnant?** ☐ YES ☐ NO **Breast Feeding?** ☐ YES ☐ NO
Date of Last Menstrual Period: _____

SKIN WARMING

* MRI Radiofrequency has the potential to cause tissue heating. Precautions will be taken to avoid this.
Alert the technologist immediately if you notice any heating sensations during your MRI scan.

PIERCINGS, COSMETIC IMPLANTS, TATTOOS AND PERMANENT MAKEUP

*A small number of patients have experienced transient skin irritation, swelling, bruising or heating sensations at the site of the piercings, cosmetic implants, tattoos and permanent makeup in association with MR procedures. **Individuals with these items should inform the technologist so precautions can be taken.**

MEDICAL HISTORY

Why are you having this test done? What is the reason?
Previous Pesticide Exposure

Where / What area is the problem? Body part involved?
whole body system

Which side (left/right/upper/lower)? whole body

When did your symptoms start? 2004

Describe the problem it is giving you?
Acute symptoms began in 2004 chronic 2005 - 2014 subsided in 2015

Check all that are applicable to your symptoms:
☒ Acute (present or a severe and intense degree)
☒ Chronic (persisting a long time / constantly recurring)
☐ Intermittent ☐ Transient (last only a short time)
☐ Primary Issue ☐ Secondary due to another issue

List any tests you had at other facilities for this problem:
Ex: Lab, X-Ray, Upper GI, BE, Ultrasound, MRI, CT
Test - Date - Where
Many they are in the System

List surgeries you have had and date of surgery:
R Knee meniscus surgery 3
2008, 2010, 2012

Do you have or ever had cancer? ☐ Yes ☒ No
if yes: What type - Where (body part)

What type of treatment did you receive and when?

Did you injure the area of interest? ☐ Yes ☐ No
if yes, describe: I dont Know thats why Im here

List all medications you are taking and what they're for:
Xanax anxiety

Have you been in the hospital within the last week?
☐ Yes ☒ No If yes, describe below:

Have you ever experienced any problem related to a previous MRI procedure or MRI contrast? ☐ Yes ☐ No

DO YOU HAVE ANY OF THE FOLLOWING?

☐ Yes ☒ No Kidney disease or kidney injury
☐ Yes ☒ No Kidney surgery, transplant, single kidney
☐ Yes ☒ No Kidney tumor or cancer
☐ Yes ☒ No Diabetes
☐ Yes ☒ No Are on dialysis
☐ Yes ☒ No Chemotherapy in the past 3 months
☐ Yes ☒ No Take medication for hypertension (follow local protocol)
☒ Yes ☐ No Past allergic reaction to gadolinium or iodine contrast
☒ Yes ☐ No Asthma or allergy

TECHNOLOGIST NOTES

CONTRAST CONSENT

Due to your medical history, or as requested by your physician, an injection of MRI gadolinium contrast may be necessary to aid the radiologist in evaluating your MRI scan.
The Food and Drug Administration has approved this agent. A very small percentage of patients receiving gadolinium may develop a headache or experience mild nausea. Rarely, local inflammation may occur at the injection site.
☐ I CONSENT to having Gadolinium contrast as needed. (Check box if you agree to contrast)
☐ I DECLINE having a Gadolinium contrast injection at this time. (Check box if you disagree to contrast)
I attest that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the MR procedure I am about to undergo.
I understand that emergency or follow-up care, if needed, is the direct financial responsibility of the patient receiving additional 3rd party services (ambulance transport to a hospital, 911 call, medical care, etc.).

Patient/Guardian Signature: _____ Date: 11-9-16

FOR STAFF USE: Screening Performed By: ☐ MR Technologist ☐ Nurse ☐ Radiologist ☐ Other: _____
Staff Signature: _____ Print Name: _____