Radiology Associates
of the Fox Valley
333 N. Commercial Street, Neenah, WI

Patient Information Form (PIF) for Wrist Symptoms

The following patient information forms are used for patients undergoing imaging of the wrist.

The forms, titled “Right Wrist” and “Left Wrist”, are used for radiographs, computed tomography (CT), and magnetic resonance imaging (MRI) examinations.

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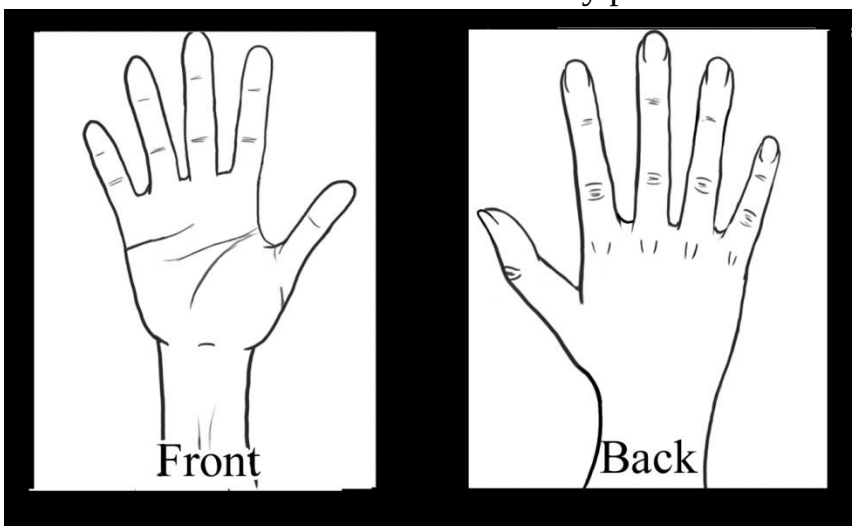
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

Right Wrist

Please mark the location of any pain:



How long have you had your symptoms?

Have you had prior surgery done on your wrist? If so, please tell us the approximate date(s) and procedure(s):

If your pain is from an injury, please tell us the date of the injury describe what happened:

Please put a check if you have any of the following:	
	Neck and arm pain with my wrist pain.
	Pain when I move my wrist.
	Decreased range of motion in my wrist.
	Pain which is worse with motion and relieved by rest.
	A lump on my wrist
	Abnormal sensation on the little finger side of my hand.
	Abnormal sensation on the thumb side of my hand.
	Decreased grip strength.

Have you ever been diagnosed with cancer? YES NO
If yes, what type? _____

FOR TECHNOLOGIST USE ONLY (Fluoro time: ____ sec)

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details:

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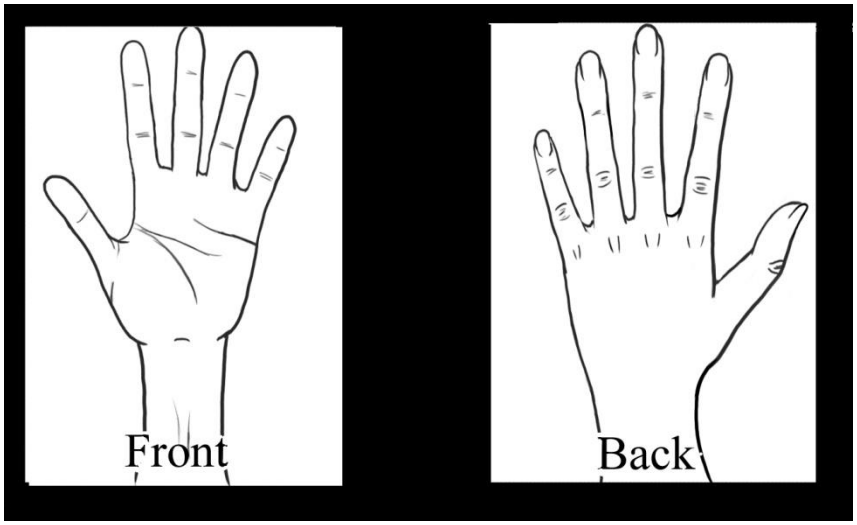
Patient Name: _____ Previous exam: _____
Date of birth: _____ Patient pregnant: YES NO
Medical Record #: _____ Patient breastfeeding: YES NO

Left Wrist

Please mark the location of any pain:



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