

EXHIBIT 2

**Form Used by Radiologic Technologists to Screen Patients before MRI**

	Data	Last Updated By	Updated DT/TM
Patient History:			
FOR FEMALE PATIENT ONLY:			
Is there any chance you might be pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Last menstrual period:			
Are you currently breast feeding?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Any kidney disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Cardiac pacemaker?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Additional preliminary/wet reading			
History of sickle cell anemia?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Surgical clips?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Dental bridge, dentures?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Hearing aides?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Clips?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Aneurysm clips	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Intracranial bypass clips	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Coronary bypass clips	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Renal transplant clips	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Other vascular clips	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Prosthesis?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Middle ear prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Orbital prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Cardiac valve prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Artificial limb/joint prosthesis	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Other (please specify)			
Bullet or bullet fragments	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Metal worker, grinder, welder	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Biosimulator	<input type="checkbox"/> YES <input type="checkbox"/> NO		
IUD	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Diaphragm	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Heart disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Extremity or spinal brace (metal implants in spine)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
Contrast and Dosage?	<input type="checkbox"/> YES <input type="checkbox"/> NO		
IV contrast (type and dosage in mL):			
Sedation given?	<input type="checkbox"/> YES <input type="checkbox"/> NO		

**Form Used by Radiologic Technologists to Screen Patients before CT**

	Data	Last Updated By	Updated DT/TM
Patient History:			
FOR FEMALE PATIENT ONLY: Is there any chance you might be pregnant? <input type="checkbox"/> YES <input type="checkbox"/> NO Last menstrual period:			
Ever received iodinated contrast? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Previous reaction to contrast? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Allergies/Hayfever? <input type="checkbox"/> YES <input type="checkbox"/> NO Drug/medications:			
Asthma/Lung Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Extrinsic—Outwardly included <input type="checkbox"/> YES <input type="checkbox"/> NO COPD <input type="checkbox"/> YES <input type="checkbox"/> NO Other—please specify:			
Do you have Kidney disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Acute <input type="checkbox"/> YES <input type="checkbox"/> NO Impaired function <input type="checkbox"/> YES <input type="checkbox"/> NO Hypertension/High blood pressure <input type="checkbox"/> YES <input type="checkbox"/> NO Other—please specify:			
Diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO Insulin dependent <input type="checkbox"/> YES <input type="checkbox"/> NO Non-Insulin dependent <input type="checkbox"/> YES <input type="checkbox"/> NO Taking diabetes related medication? <input type="checkbox"/> YES <input type="checkbox"/> NO If so, CONSULT W/ RADIOLOGIST			
History of sickle cell anemia? <input type="checkbox"/> YES <input type="checkbox"/> NO			
General debilitation? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Other disease? <input type="checkbox"/> YES <input type="checkbox"/> NO (Multiple Myeloma, Strokes, Cancer)			
Contrast and Dosage? <input type="checkbox"/> YES <input type="checkbox"/> NO Oral contrast (Type and dosage in ml): IV contrast (Type and dosage in ml):			