Report of Patient Peripheral Nerve Stimulation Form

Report Date **Date of MR Exam**

Hospital Name **Telephone Number**

Name of Reporting Health Care Pofessional

Patient Age **Patient Weight** **Patient Height**

Patient Pathology **Patient Medications**

Exam Number **Series Number**

PSD (GRE, SE, FSE, EPI, IR)

TR (ms) **TE** (ms) **FOV** (cm)

Slice Thickness (mm) **Interslice Spacing** (mm)

Slew Rate (T/m/s) **Frequency Encoding Direction**
(RL, AP, SI)

Were patient's hands clasped?

dB/dt (% peripheral nerve or T/s)

Stimulation Severity
(1=very mild, 2=mild, 3=uncomfortable, 4=very uncomfortable)

Stimulation Description and Location