DIAGNOSE ZENTRUM BRIGITTENAU

MRI

[Patientenname], [Geb.datum]

In order to determine possible side effects, we kindly request to **answer the following questions**:

Do you have a cardiac pacemaker?	☐ yes ☐ no
Have you ever had surgery on the head or heart? Do you have any implants? E.g. defibrillator, heart valve, ear implant, aneurysm clip, insulin pump, pain control pump, prosthetic joint, shunt, port-a-cath, stent If yes, please specify?……	☐ yes ☐ no
Do you have any metal pieces or fragements in your body? If yes, please specify:……	☐ yes ☐ no
Are you wearing a hearing aid?	☐ yes ☐ no
Have you ever undergone an MRI scan?	☐ yes ☐ no
Did any problems occur? If yes, please specify:……	☐ yes ☐ no
Do you suffer from claustrophobia? Caution: If you are given a sedative due to claustrophobia, you are not allowed to actively parttake in traffic or operate heavy machinery.	☐ yes ☐ no
Do you suffer from kidney disease or have you had kidney surgery?	☐ yes ☐ no
Do you have infectious diseases e.g. hepatitis C or HIV?	☐ yes ☐ no
Do you suffer from diabetes? If your are wearing an insulin sensor/ pump, it needs to be taken off.	☐ yes ☐ no
Do you have allergies, asthma or drug intolerances? If yes, please specify:…….. Allergies to iodine are irrelevant for the examination in the MRI	☐ yes ☐ no
Do you have any pain patches or hormone patches?	☐ yes ☐ no
Do you have any recently made tatoos? Are you wearing body piercings or jewellery?	☐ yes ☐ no
Weight: ……..kg **Height: ……..cm**	

Questions about the body region to be examined:	
Where are the complaints? Which joint or which section of the spine is affected? ……	
Are you aware of any accidents or injuries? If yes, what happened and when? ……	☐ yes ☐ no
Have you already had an operation, puncture or arthroscopy in this area? If yes, when and in which area? ……	☐ yes ☐ no

Please turn page!

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[Patientenname], [Geb.datum]

For female patients:	
Is there a possibility that you might be pregnant?	☐ yes ☐ no
Are you currently breastfeeding?	☐ yes ☐ no
Do you have a cupper IUD?	☐ yes ☐ no

The examination takes place in a magnetic field. Any metal objects, as well as watches, glasses, jewelry, wallets, keys, etc., must be removed before the examination.

I confirm that I have read and understand the text and that I have answered the questions concerning my person to the best of my knowledge. My questions have been adequately answered during a personal conversation. I was informed to remove any metal objects. **I consent to the conduct of the proposed MRI examination.**

Date

Signature of the patient or legal guardian

Please hand this form to the imaging personnel before the examination

Unterschrift Arzt/Ärztin

Unterschrift MTD

Blutbefund: Krea: ..... ml/dl GFR: ..... TSH: ..... µU/ml

Datum Blutbefund: .....

KM-Allergie ☐ Ja ☐ Nein Prophylaxe: .....

Venflon: ☐ Ja ☐ Nein gelegt von: .....

KM: .....