DIAGNOSE ZENTRUM BRIGITTENAU

MRT

Name: .....

Date of birth: .....

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
Do you have any recently made tatoos? Are you wearing body piercings or jewellery?	☐ yes ☐ no
For female patients:	
Is there a possibility that you might be pregnant?	☐ 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. In einem persönlichen Gespräch sind meine Fragen ausreichend beantwortet worden. **Ich stimme der Durchführung der vorgeschlagenen MRT-Untersuchung zu.**

_____ _____

Date Signature

Vom DZB auszufüllen:

_____ _____

Name Begleitperson Unterschrift MTD