DIAGNOSE ZENTRUM BRIGITTENAU

MRI

Name: .....

Date of Birth: .....

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

Weight: ……..kg	**Height: …….cm**

□ yes □ no	**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 fragments 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?**

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

Please turn page!

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MRI

Name: .....

Date of Birth: .....

Questions about the body region to be examined:
Where are the complaints? Which joint or which section of the spine is affected? …… …… ……
□ yes □ no **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? ……

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.

Please note: If you bring previous findings after the examination, no comparisons can be made.

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: .....