



Name:

Date of Birth:

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

Weight:kg	Height:cm
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<input type="checkbox"/> yes <input type="checkbox"/> no Do you have a cardiac pacemaker?
<input type="checkbox"/> yes <input type="checkbox"/> 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?.....
<input type="checkbox"/> yes <input type="checkbox"/> no Do you have any metal pieces or fragments in your body? If yes, please specify:.....
<input type="checkbox"/> yes <input type="checkbox"/> no Are you wearing a hearing aid?
<input type="checkbox"/> yes <input type="checkbox"/> no Have you ever undergone an MRI scan?
<input type="checkbox"/> yes <input type="checkbox"/> no Did any problems occur? If yes, please specify:.....
<input type="checkbox"/> yes <input type="checkbox"/> 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.
<input type="checkbox"/> yes <input type="checkbox"/> no Do you suffer from kidney disease or have you had kidney surgery?
<input type="checkbox"/> yes <input type="checkbox"/> no Do you have infectious diseases e.g. hepatitis C or HIV?
<input type="checkbox"/> yes <input type="checkbox"/> no Do you suffer from diabetes? If your are wearing an insulin sensor/ pump, it needs to be taken off.
<input type="checkbox"/> yes <input type="checkbox"/> no Do you have allergies, asthma or drug intolerances? If yes, please specify:..... Allergies to iodine are irrelevant for the examination in the MRI
<input type="checkbox"/> yes <input type="checkbox"/> no Do you have any pain patches or hormone patches?
<input type="checkbox"/> yes <input type="checkbox"/> no Do you have any recently made tatoos? Are you wearing body piercings or jewellery?

For female patients:
<input type="checkbox"/> yes <input type="checkbox"/> no Is there a possibility that you might be pregnant?
<input type="checkbox"/> yes <input type="checkbox"/> no Are you currently breastfeeding?
<input type="checkbox"/> yes <input type="checkbox"/> no Do you have a cupper IUD?

Please turn page!



Name:

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Questions about the body region to be examined:	
Where are the complaints? Which joint or which section of the spine is affected?	
.....	
.....	
.....	
<input type="checkbox"/> yes <input type="checkbox"/> no	Are you aware of any accidents or injuries?
If yes, what happened and when?	
<input type="checkbox"/> yes <input type="checkbox"/> 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.
- Mammography and prostate examinations: If a pathological finding is present, you will be informed by telephone and asked to come to the practice to sign a confirmation of receipt.

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	<input type="checkbox"/> Ja <input type="checkbox"/> Nein	Prophylaxe:	
Venflon:	<input type="checkbox"/> Ja <input type="checkbox"/> Nein	gelegt von:	
KM:			