DIAGNOSE ZENTRUM BRIGITTENAU

MRI

Name: .....

Date of birth: .....

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

☐ yes ☐ no	**Do you have a cardiac pacemaker?**
☐ yes ☐ no	**Have you ever had surgery on the head or heart?** If yes, please specify?……
☐ yes ☐ no	**Do you have any implants, metal pieces or fragements in your body?** 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	**Are you wearing a hearing aid?**
☐ 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?**

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

Vom DZB auszufüllen:

_____ _____

Unterschrift Arzt/Ärztin Unterschrift MTD