RTS RADIOLOGIE Trier | Saarburg

Questionnaire for MRT (magnetic resonance tomography)

Patient label

Family name: First name: Date of birth:

<u>Personal information</u> ---- to be completed by the staff

Anamnese:

Kreatinin:_____ **GFR:**_____

Protokoll: _____

VA von Pat. mitgebracht? O nein O ja
VA angefordert? O nein O ja

Wo?_____ Wann:_____

Dear patient,

We would like to give you information about the MRI/IRM and we also need to know important medical things about before we can start the examination.
The magnetic resonance imaging (MRI and IRM) produces cross-sectional images of the body.

The examination is divided into a plurality of examination portions. Each section can take up to 10 minutes. The total scan time is usually about 20 to 30 minutes. During the examination you will hear at times a loud knocking noise.

To get the best results you should lie as quiet as possible while the examination runs.

If you suffer from claustrophobia, please do not hesitate to tell us before the examination starts.
You've got always have the opportunity to communicate with the staff, which is constantly monitoring you. We also can provide you a hearing protection device.
For some medical indications will an injection (intravenous) of contrast agent be necessary. Thereof you will perceive generally nothing. Very rarely, there may be allergic reactions like sickness, itching or nausea, which usually subside by themselves. Extremely rare severe reactions of cardio - vascular system, throat swelling, respiratory distress, which makes a medicinal or inpatient treatment necessary.
As in any vein puncture swelling and local irritation on skin can be possible.

Due to the strong magnetic field there are some important contraindications that have to be regarded obligatory before entering the examination room.

please turn page →

We therefore ask you to answer the following questions carefully (Please check one):

Have been the any kind of the following devices implanted?		
Heart pacemaker	O no	O yes
Neurostimulator / ventriculoperitoneal shunt	O no	O yes
Inner ear Prosthesis (Cochlear implantat)	O no	O yes
Insulin or analgestic pump	O no	O yes
Any other implants	O no	O yes
Do you wear a hearing aid?	O no	O yes
Do you wear vascular stents, coronary bypasses or post operation-clips?	O no	O yes

If **yes**, since when and how many? _____

Do you wear tattoos, piercings or Permanent-make-up?	O no	O yes
Do you wear a medicament patch?	O no	O yes
Do you wear a dental prosthesis?	O no	O yes
Do you have one of these metals in body?		
- **Metal/shrapnel**	O no	O yes
- Metal nail due to bone fracture	O no	O yes
- Joint prosthesis	O no	O yes
Did you ever have an operation on head or eyes?	O no	O yes
Did you ever have an operation on the region that will be examined now?	O no	O yes

If **yes**, when? _____

Are there any allergies known to you?	O no	O yes
Do you suffer from a kidney disease?	O no	O yes

Are there any previous radiological examinations of the current interesting region? (also x-ray or computer tomography) O no O yes

If **yes**, when and where was it? _____

Are you pregnant?  O no O yes

Please fill in your body weight: ..... kg

1. Prior to the examination it is absolutely necessary that all metal parts, such as removable dental prosthesis, jewelry, keys, lighters, coins, watches, hearing aids, glasses, etc. are left in the cabin **(even credit card / EC-cards / parking ticket)**
2. **Only in case of studies of the elbow or hand:**
   For this kind of examination is a special posture necessary. Sometimes, problems in movement can temporary occur afterwards.

I have understood the questionnaire and answered questions conscientiously.	O yes	O no
I agree to an administration of contrast agent if needed.	O yes	O no
I **have no further questions and agree with the examination.**	O yes	O no
I do agree to an electronic archiving (storage) of the questionnaire.	O yes	O no

I do agree that the findings and images are conveyed to and by my attending physicians or hospitals or medical practices. O yes O no

I am aware that I can revoke this declaration at any time in whole or in part for the future.

Date: _____ signature patient: _____

Date: _____ signature doctor: _____