



Questionnaire for MRT (magnetic resonance tomography)

Patient label

Family name:

First name:

Personal information ---- to be completed by the staff.

Anamnese:

Kreatinin: _____ GFR: _____

Protokoll: _____

VA vom Patient mitgebracht? nein ja

VA angefordert? nein 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 without the exposure of radiation

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.



Have been the any kind of the following devices implanted?

- | | | |
|--|--------------------------|---------------------------|
| Heart pacemaker | <input type="radio"/> no | <input type="radio"/> yes |
| Neurostimulator | <input type="radio"/> no | <input type="radio"/> yes |
| Inner ear Prosthesis (Cochlear implantat) | <input type="radio"/> no | <input type="radio"/> yes |
| Insulin or analgesic pump | <input type="radio"/> no | <input type="radio"/> yes |
| Any other bioelectrical implants | <input type="radio"/> no | <input type="radio"/> yes |
| Do you wear a hearing aid? | <input type="radio"/> no | <input type="radio"/> yes |
| Do you wear vascular stents or post operation-clips? | <input type="radio"/> no | <input type="radio"/> yes |

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

Do you have a bypass or arteriole-venous shunt? no yes

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

Do you wear tattoos, piercings or Permanent-make-up?
 no yes

Do you wear a medicament patch? no yes

Do you wear a dental prosthesis? no yes

Do you have one of these metals in body?
 - **Metal/shrapnel** no yes
 - Metal nail due to bone fracture no yes
 - Joint prosthesis no yes

Did you ever have an operation on head or eyes? no yes

Did you ever have an operation on the region that will be examined now? no yes

If **yes**, when? _____

Are there any allergies known to you? no yes

Do you suffer from a kidney disease? no yes

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

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

For women - are you pregnant? no yes

Are you breastfeeding? no 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.

yes no

I agree to an administration of contrast agent if needed. yes no

I have no further questions and agree with the examination. yes no

I do agree to an electronic archiving (storage) of the questionnaire. yes no

I do agree that the findings und images are transferred to my attending physicians or hospitals or medical practices. yes 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:** _____