MRT AKADEMIE

MRI patient safety questionnaire

Last name, given name:
Date of birth:
Weight in kg:
Telephone number: _____

Which part of your body shall be examined today?

_____

○ left ○ right

What is troubling you and where does it hurt?

_____

Did or do you have any tumor?

○ yes ○ no

Have you had an operation on this part of your body? If so, when and what was done?

_____

Are you suffering from any chronic disease?

○ yes ○ no

Are you suffering from a restricted kidney function?

○ yes ○ no

Do you have any allergies?

○ yes ○ no

Do you have a pacemaker, defibrillator or wires? If so, please come forward and inform us.

○ yes ○ no

Do your have any medical devices or implants on or inside your body? If so, which and where?

_____

Do your have any metal or parts in your body (i.e. aortic clips, bone rods, fragments)?
If so, which and where?

_____

Are you currently under medication?
If so, what do you ingest?

_____

Female patients: Could you be pregnant?

○ yes ○ no

In case an injection of contrast agent may aid in the evaluation of the study, do you agree with it? The radiologist will inform you about the risks and benefits.

○ yes ○ no

Have you ever suffered from a contrast agent intolerance during an MRI examination?

○ yes ○ no

The technologists and radiologists will gladly answer any further question you may have. Please confirm your consent with the planned exam by signing below.

_____

Date and signature