QUESTIONNAIRE FOR THE MRI EXAMINATION

LAST NAME, FIRST NAME: _____ DATE OF BIRTH: _____

WEIGHT: _____ HEIGHT: _____

Please hand over any previous images or doctor's reports of previous examinations of the body parts that need to be examined before today's examination. Please answer all the following questions carefully and complete the form!

1) What kind of complaints led you to the visit of your referring physician? (please give a short description of your symptoms)

_____

since when: _____

2) Please indicate the side of the body that is affected.

○ left ○ right

3) Have you ever undergone surgery in the area/ the organ of the body part that will be examined?

○ yes ○ no WHEN _____

4) Have you been diagnosed with an acute or chronical infectious disease? (e.g. tuberculosis, AIDS, hepatitis) or do you have an impaired renal function?

○ yes ○ no

5) Are you/ have you been a cancer patient?

○ yes ○ no

6) Which organ is/ has been diagnosed with cancer?

_____

OPERATION _____ WHEN _____

RADIOTHEARPY _____ WHEN _____

CHEMOTHERAPY _____ WHEN _____

7) Have you ever had incompatibilities or problems with earlier MRI examinations?

○ yes ○ no

8) Have you any allergies to e.g. medicines, hay fever, food allergies or cosmetics? (if necessary show us your allergy passport!)

○ yes ○ no

9) Do you suffer from claustrophobia? (anxieties in confined spaces)

○ yes ○ no

Do you have any more questions? If you do have more questions, you can resolve the issues with our assistant before the examination.

Annotations of the doctor during the explanatory conversation: _____

_____

_____

SIGNATURE OF THE PHYSICIAN

10) Do you have a pacemaker or any other electrical devices such as an insulin pump, hearing aid, defibrillator or a neurostimulator?

○ yes ○ no

11) Do you have any other pieces of metal in your body (e.g. vascular clamps, stents, metal splinters, metal prosthetics, implants, intrauterine device)? Do you have a piercing or dental prosthetics that you could take out?

○ yes ○ no

If yes: What kind of metal, in which place?

_____

_____

12) Have you ever had a metal splinter in your eye?

○ yes ○ no

13) Has this metal splinter been removed completely by an ophthalmologist?

○ yes ○ no

14) Do you wear any permanent make up or tattoos?

○ yes ○ no

15) Women of childbearing age:

Are you pregnant?

○ yes ○ no

Are you currently nursing?

○ yes ○ no

○ I would like to receive a copy of the completed explanatory leaflet.

DECLARATION OF CONSENT:

(Please mark with a cross)

○ I have read the explanatory leaflet carefully and I am well informed about the planned examination. I confirm that I have answered all questions completely and in the best of my knowledge.

○ I do not have any further questions and herewith consent to the examination after having had sufficient time to think about it.

○ I consent to an injection of a contrast medium should it be necessary during the examination.

○ I agree that my data will (according to the General Data Protection Regulation (GDPR/DSGVO)) be saved for my treatment and transferred if necessary.

_____

LOCATION /DATE

_____

SIGNATURE OF THE PATIENT / OR GUARDIAN