

Magnetic resonance imaging (MRI) safety questionnaire, advice and written informed consent of a patient in accordance with Article 6 of Act No. 576/2004 on Healthcare

Magnetic resonance is a safe and painless examination method. As a patient's examination takes place in a strong magnetic field, metal objects in your body may be dangerous or cause interference. Please provide us with the following important information before your examination.

Surname and name:..... **Year of birth:** **Weight:** (kg)

Have you ever undergone MRI?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date of last MRI	
Have you ever had a surgery?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If so, which organ?	

Pacemaker/cardiac stimulator, defibrillator	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Ocular prosthesis/artificial lens	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Insulin pump	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Endoprosthesis - artificial joint	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Electronic implant	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Orthopaedic implant	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cochlear implant	<input type="checkbox"/> YES	<input type="checkbox"/> NO	VP Shunt	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Neurostimulator	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Metal fragments	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Clips/staples, stents, filters	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Metal dentures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial heart valve	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Removable denture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Claustrophobia	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Tattoo, permanent make-up	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergy	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If so, to what?		
Other objects and implants	<input type="checkbox"/> YES	<input type="checkbox"/> NO	What and where?		
Have you ever been administered a contrast medium during the MRI?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	If so, did you have side effects, such as warmth, redness, itching, swelling, shortness of breath, dizziness or collapse, after the administration?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
For women: Are you pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Are you breastfeeding?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

It is recommended not to wear makeup for head MRI.

CAUTION

- 1. For the above implants and bodies, it is necessary to confirm compatibility with MRI (provide the manufacturer's certificate).**
2. All removable metal objects must be removed before MRI. Follow the radiologist's instructions.
3. Patients with VP drainage in the brain must undergo a neurosurgical check before and after the MRI using the 3.0T scanner.
- 4. Do not bring valuables and weapons to the MRI.**

It is sometimes necessary to administer a contrast medium during the MRI examination. The MRI contrast medium (gadolinium) is applied by a thin needle into a vein, usually in the forearm. During the administration of the contrast medium, you can feel a puncture and then a feeling of "administration", which is normal. The MRI contrast medium is sufficiently safe, but there may be side effects as with any medicinal products. Our medical staff is trained to cope with such situations.

Please continue filling in the details on the next page.

SELF-PAYER

I was informed about the nature of the MRI examination. **I agree** with the examination. **I agree** with the administration of a contrast medium, if required.

I declare that I am requesting the MRI examination outside public health insurance at my own expense and at my own request. I was informed that my health insurance company will not reimburse this examination. I agree with a cash payment and I agree with the offered price of the examination.

* I, the undersigned patient, hereby grant CONSENT to this diagnostic centre, in which I have been examined, to process my phone number and to provide it to Pro Diagnostic Group, a.s., with its registered seat at Malý trh 2/A, Bratislava, Company ID: 46 112 928, for the purposes of using the services of the web portal www.eriologia.sk for 20 years after the last examination by this diagnostic centre.

Phone number*:

Signature: (relation to the patient:) Date:

This diagnostic centre authorised Pro Diagnostic Group, a.s. to process personal data of examined patients in the extent of the information that must be included in a report for a doctor who referred the patient for further healthcare under Article 8 (6) of the Healthcare Act and to speed up and simplify further healthcare, and to enable access to the portal www.eriologia.sk.



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