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MRI SAFETY QUESTIONNAIRE AND CONSENT FORM

Name, Surname _____ DOB _____

Type of examination _____ Date _____ Height _____ Weight _____

Before undergoing an MRI examination, with or without the administration of contrast, it is required to fill in the below questionnaire. In case of question/clarification needed, please inform the Radiographer who is going to proceed with your exam.

1. Do you have any from down listed?		
a. Stent	YES	NO
b. Cardiac pacemaker	YES	NO
c. Aorto-coronary bypass	YES	NO
d. Artificial heart valve	YES	NO
e. Surgical plates	YES	NO
f. Aneurysmal clips	YES	NO
g. Replacement of joint(s)	YES	NO
h. Eye, ear or dental implant	YES	NO
i. Any other metal fragments (please specify)	YES	NO
2. Have you ever had any adverse reaction after MR contrast injection?	**YES**	**NO**
3. Do you suffer from any of the following?		
a. Claustrophobia	YES	NO
b. Renal Disease (including renal surgery, kidney transplantation)?	YES	NO
c. Diabetes mellitus	YES	NO
d. Hyperthyroidism	YES	NO
e. Gout	YES	NO
f. Heart Failure	YES	NO
4. Are you on dialysis?	**YES**	**NO**
5. Do you have a recent (up to 4 weeks) laboratory creatinine result?	**YES**	**NO**
6. (for female patients):		
a. Are you pregnant or is there any possibility of being pregnant?	YES	NO
b. Are you breast-feeding?	YES	NO
c. Do you have an intrauterine contraceptive device (spiral)?	YES	NO

☐ I confirm that I have been fully informed about all stages of the above-mentioned radiology imaging, including contrast media administration and associated risks, and, therefore, **give my consent** to the above-mentioned medical examination **with contrast media administration**. I also confirm that the proposal is entirely medically indicated and recommended and is in accordance with my consent to its performance.

☐ I do not consent to undergo the above-mentioned examination

☐ I confirm that I have been fully informed about all stages of the above-mentioned radiology imaging, including contrast media administration and associated risks, and, therefore, **give my consent** to the above-mentioned medical examination, but **without contrast media administration**. I also confirm that the proposal is entirely medically indicated and recommended and is in accordance with my consent to its performance.

Name of patient or legal representative: _____

Signature of patient (or legal representative): _____

(For Radiographer)

(contrast label)

SeCre: _____

eGFR: _____

_____

Name, Surname of Radiographer:

_____

Signature of Radiographer: