RADCARE
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Questionnaire Magnetic Resonance Imaging (MRI)

To be able to evaluate your potentially increased risk, we ask that you kindly answer the following questions.

Name of patient

Date of birth | Room Nr. | Weight (kg) | Height (cm) | Krea/GFR

	Yes	No
Have you ever undergone an MRI scan? If yes, did any problems arise? Please specify?	☐	☐
Do you suffer from claustrophobia?	☐	☐
Do you suffer from kidney disease or have you ever had kidney surgery?	☐	☐
Are you suffering from diabetes?	☐	☐
Do you have allergies or drug intolerances*? If yes, please specify:	☐	☐
Do you have asthma?	☐	☐
Do you currently have or have you ever had a pace maker?	☐	☐
Did you ever undergo surgery of the heart, head or a joint? If yes, do you have any implants, please specify? E.g. defibrillator, heart valve, ear implant, aneurysm clip, insulin pump, pain control pump, prosthetic joint, shunt, part-a-cath, stent **Please take your implant pass to examination!**	☐	☐
Do you have any metal pieces or fragments in your body? E.g. medullary nail ... If yes, please specify:	☐	☐
Do you have any tattoos, are you wearing body jewellery (piercings)?	☐	☐
For female patients: Is there a possibility that you might be pregnant?	☐	☐
For female patients: Are you using the spiral for birth control?	☐	☐
I agree to receive an injection with a contrast medium.	☐	☐
If MRI of prostate: Do you know your PSA?		

I confirm that I have read and understood the text and that I have answered the questions concerning my person to the best of my knowledge. I consent to the conduct of the proposed MRI examination. My questions have been adequately answered during a personal conversation.

Date/time	Patient's signature or legal guardian's signature	Physician's name and signature	Med. tech. employee's name and signature

* Allergic reactions to MRI contrast media are extremely rare. Allergies to iodine are irrelevant in connection with this examination.