



MAGNETIC RESONANCE IMAGING

I, (name and surname) _____

As (patient legal representative)

Date of birth _____ Weight _____

Address _____

City _____ Telephone _____

Please read and complete this form. If you have any doubts don't sign it until you have spoken to someone from this department before having the test

You will be having a MRI, requisitioned by your doctor, and some metal object can interfere with the magnetic field. It is very important to carefully read and answer the following questions, USING YES OR NOT. From your answers we can establish whether is convenient or not for you to have the Magnetic Resonance requested

1. ARE YOU ASTHMATIC?
2. ARE YOU ALLERGIC TO ANY MEDICINE OR IODINE CONTRAST?
3. HAVE YOU BEEN OPERATED FOR ANEURISM?
4. HAVE YOU GONE THROUGH THIS TEST BEFORE?
5. HAVE YOU UNDERGONE SURGERY?
6. WHAT KIND?
7. DO YOU HAVE ANY METAL IMPLANTS?
8. A PACEMAKER?
9. A MEDICINE PUMP?
10. A BONE STIMULATOR?
11. HEART VALVES?
12. A HEARING AID?
13. FILTERS?
14. FALSE TEETH (REMOVABLE OR OTHER WISE)?
15. ORTHOPAEDIC LIMBS OR SIMILAR?
16. METAL CLIPS IN THE BRAIN, TORAX OR ABDOMEN?
17. OTHER OBJECTS?
18. HAVE YOU WORKED WHERE THERE WERE METAL SHAVINGS?
19. HAVE YOU HAD ANY EHE ACCIDENT PRODUCED BY METAL OBJECTS?
20. ARE YOU OR DO YOU SUSPECT YOU ARE PREGNANT?

I have carefully read this questionnaire, answering all the questions to the best of my knowledge and I have been duly informed as to the nature and type of examination that I am to have I therefore give my permission for the test to be done

Signed, the patient or legal representative

Mr/Mrs

Marbella