

Patient Information on Magnetic Resonance Imaging

- Disclosure and Consent Form -

Please read prior to your test and answer the questions on the back.

Dear patient!

Magnetic resonance imaging (MRI) is a modern medical imaging technique which provides detailed cross-sectional images of all regions of the human body without the use of x-rays. For this test you will be placed in a strong, cylindrical magnet. This aligns the numerous hydrogen nuclei (protons) in the human body in the same direction and then purposefully excites them with special radio waves, which causes the unavoidable typical knocking sound of this test, which is harmless. A very powerful computer system then converts the returned signal into tomographies with levels which can be freely selected by the radiologist.



This scan is not suitable for people with pacemakers!

For pregnant women and if there are foreign metal objects in the body, e.g. prosthetic joints, metal slivers or clips after a surgery, it must be decided on a case by case basis whether MRI is suitable. On the reverse of this form you will find questions to help determine this. The magnetic field strengths used are no cause to be concerned about harmful effects on the body. The skin under tattoos may temporarily briefly feel warm due to the radio waves. If abnormal situations arise, you can also notify us during the scan.

Some cases require administering a contrast agent into the arm vein. This does not contain iodine and is well tolerated by those with healthy kidneys. In patients with limited kidney function, the dosage can be adjusted, or it may be necessary to use a contrast agent other than that typically used. Therefore, please bring your current results of blood tests (serum creatinine or creatinine clearance/GFR) to assess kidney function.

MRI contrast agents are excreted through the kidneys. In extremely rare cases, however, they can trigger a medical condition (so-called nephrogenic systemic fibrosis = NSF), which is accompanied by non-treatable connective tissue disorder of the skin and can lead to the limiting of movement of the joints. As the condition progresses, organs can become damaged. Patients with serious kidney diseases or before or after a liver transplant are particularly at risk.

In rare cases, the use of contrast agents can cause mild allergy-like skin reactions along with feeling unwell. In extremely rare cases, more serious allergic reactions can occur.

In rare cases, the contrast agent can leak into the arm at the injection site when the contrast agent is infused. If you feel pain at the injection site when contrast agent is being infused, please immediately notify the physician during the procedure.

Since you will be surrounded by a strong magnetic field in the examining room, all metal objects, e.g. keys, coins, lighters, watches, eyeglasses, jewellery, belts or objects sensitive to magnets such as credit or debit cards, mobile phones or hearing aids must be removed prior to the procedure (outside of the examination room).

If you have anxiety or claustrophobia, we can administer a sedative prior to the procedure. Since your memory, reaction and judgement will be impaired for up to 24 hours, you should not make any important decisions after the procedure, drive, engage in risky activities, or consume alcohol or other centrally active substances (e.g. sedatives). You must be accompanied when leaving our medical office and must ensure you will have competent care afterwards.

During the scan, which involves a knocking sound that cannot be avoided due to the technology used, you should be lying still and relaxed, as any movement will interfere with the imaging and prolong the scan time, which is typically between 20 and 40 minutes.

After the scan the physician will assess the images and write a medical report. This will automatically be forwarded to the referring physician within three to four business days. If you would like to receive your images and findings the day of your scan, you will typically have to wait a short time.

We require some information from you to be able to properly plan the scan and enable exact interpretation of it. Please answer the questions on reverse.

Last Name:	_____
First Name:	_____
Date of Birth:	_____
Telephone Number:	_____

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Please fill in your age _____, height _____ and your weight _____!

The following information is required to avoid risks:

- | | Yes | No |
|---|--------------------------|--------------------------|
| - Do you have a pacemaker or defibrillator implanted? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you have artificial heart valves ? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Have you had vessel clips implanted? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you have stent grafts? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Have you had surgery of the bones or joints and have metal parts implanted?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, where: _____ | | |
| - Do you have a cochlear implant , analgesic or insulin pump ? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you wear hearing aids ? (They have to be removed outside of the examination room)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you have tattoos or piercings ? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you have a transmittable disease (hepatitis, HIV, etc.)? Which: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| - Are you allergic to contrast agents ? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Is there a possibility you may be pregnant ? Are you currently breastfeeding ?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you have a kidney disorder ? | <input type="checkbox"/> | <input type="checkbox"/> |
| - Creatinine level/eGFR: _____ / _____ | | |

The following questions will help us best adapt the procedure to your specific condition:

- If this procedure is due to current symptoms (pain, swelling, etc.), please explain the type, location and for how long:

 - Are your problems related to an **accident**? If so, please explain when and the events:

 - Have you had prior surgeries, tumours or chronic conditions? Please explains the details (What? When?) below:

- | | | |
|--|--------------------------|--------------------------|
| - Have you ever had imaging examinations of this specific body part? | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, when and where? _____ | | |
| - Where are the images from this test? _____ | | |

If you have any further questions, please ask us prior to your scan. If you agree to the planned MRI and being administered contrast agent if required for your specific scan, please sign below.

RNZ archives this patient information and consent form in compliance with the statutory obligation to preserve records and can be accessed at any time during this period. Yes

I hereby waive my right to receive a copy of this patient information and consent form.

Place, Date Patient's Signature Physician's Signature