For the doctor
If one or more of the items in the above table are answered 'Yes', are they compatible with conduction the MRI examination? ☐ Yes ☐ No

Being aware of the harm caused to my health, or the health of my relative, from the activity of the magnetic field due to the incorrect answering of the question, I declare that I have correctly answered the above questions. At the same time, following the information received on the risks of intravenous anaesthesia during MRI, I agree to the injections.
Name and signature of the patient/parent/relative taking the responsibility:

....

....

....

Name and signature of the doctor/clinician,
who based on the verification/interview on the above points in the form, allows the examination.

....

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MRI EXAMINATION FORM

For the patient: This form should be fully completed on both sides. If not completed the examination will not be carried out. Please ask your doctor to complete it correctly. Accurate completion helps for a better examination.

For the doctor: Please complete this form fully and accurately.

Name ....

DoB: dd- mm- yyyy .... Weight in kg. ....

Indication

....

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....

....

....

Region of examination (only one Region for each, and Examination Plan)

....

....

....

....

....

....

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1) Head ☐ 2) Cervical colon ☐ 3) Thoracic 4) Lumbar ☐
5) Abdomen ☐ 6) Knee ☐ 7) Talocrural ☐ 8) Coxofemoral ☐
9) Other ☐

1) Have you ever had any surgical or invasive procedure? ☐ No ☐ Yes
If yes, please write below

Data

2. Has you previously had a MRI ☐ No ☐ Yes
If yes, describe below the latest one:

Body part scanned in the latest MRI Data

3. Do you have any metallic shavings (or any other foreign bodies) ☐ No ☐ Yes
in the eye or any other part of the body?
If yes, describe them

4. Are you pregnant or do you have delays in the menstrual cycle? ☐ No ☐ Yes

5. Are you breastfeeding? ☐ No ☐ Yes

6. Are you taking any medications? Have you taken any medications in the past? ☐ No ☐ Yes

If YES, please describe:

7. Do you have any blood or kidney diseases, or epileptic fits? ☐ No ☐ Yes
Do you have elevated levels of azotemia and creatinina?
If Yes, please describe:

8. Do you suffer of asthma, lung disease, allergic reactions from contrast dyes ☐ No ☐ Yes
medications, stinging or something else? If YES, describe them:

Some of the following points may be dangerous for the health of the patient and may interfere with the MR examination. Please check carefully and answer correctly each of them.

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For the doctor, patient or the relative:

Do youconfirm any of the following:

☐ Yes ☐ No Implantable Cardioverter-Defibrillator (ICD)
☐ Yes ☐ No Carotid Artery Disease
☐ Yes ☐ No Implantable infusion for a medication
☐ Yes ☐ No Growth/fusing bone stimulator
☐ Yes ☐ No Cochlear, Otologic or ear implant
☐ Yes ☐ No Artificial limbs of joints
☐ Yes ☐ No Electrodes (in the head, body or brain)
☐ Yes ☐ No Stents, coils or intravascular filters
☐ Yes ☐ No Shunts (spinal or intravascular)
☐ Yes ☐ No Magnet assisted implant
☐ Yes ☐ No Transdermal injection systems (nitro-glycerine)
☐ Yes ☐ No Intrauterine devices or diaphragms
☐ Yes ☐ No Internal wires of electrodes

☐ Yes ☐ No Neurostimulator
☐ Yes ☐ No Insulin pump
☐ Yes ☐ No Aneurysm clips
☐ Yes ☐ No Vascular catheters
☐ Yes ☐ No No Swan–Ganz catheter
☐ Yes ☐ No Make-up (Lips, eyes, face)
☐ Yes ☐ No Tattoos
☐ Yes ☐ No Aortal clips
☐ Yes ☐ No Any metallic fragments
☐ Yes ☐ No Claustrophobia
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Movement disorder

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