Crea: _____ GFR: _____

KM: _____

Flow: _____

MAGNET RESONANZ
INSTITUT BLUDENZ
DDR. FÄßLER

Name

Date of Birth

Body Weight (approx.) _____ kg

		YES	NO
I.	Do you have a:		
	Cardiac Pacemaker?	O	O
	Inner Ear Implant?	O	O
	Medication Pump, Neurostimulator?	O	O
	Blood Sugar Sensor (Freestyle Libre, …)	O	O
II.	Is/Are there any:		
	Metal Pieces	O	O
	Vessel Clips	O	O
	Metal Splinters/Shrapnels	O	O
	Ventricular Shunt	O	O
	in your body?		
III.	Do you have a new made **tattoo/permanent make-up** (< 2 weeks)?	O	O
IV.	Have you ever had an **MRI examination?** Place: ……. (approx.) Date:……. Body Region…….	O	O
V.	Have you ever undergone **head, heart, ear, eye, vascular surgery?** O O O. O O	O	O
VI.	Have you ever got the body region **operated**, that is being **examined today?** Place: ……. (approx.) Date: …….	O	O
VII.	**If necessary**, the **doctor will order to administer a contrast media.** Do you consent to that?	O	O
VIII.	Have there ever occured any **MR contrast media intolerances** in previous examinations?	O	O
IX.	Do you suffer from **renal dysfunction** or are you a **dialysis patient**?	O	O
X.	Do you have a **transplanted liver**?	O	O
XI.	Do you have any **infectious diseases** (hepatitis, HIV, etc.)?	O	O
XII.	Do you have or have you ever had a **tumor or cancerous disease**?	O	O
XIII.	**For women only:** Is there a possibility of **pregnancy?**	O	O

I herewith confirm that I understand the above questions and have carefully read and filled in the information sheet. I also consent to the examination.

Date..... **Signature.....**

<u>will be filled in by us</u>

Trauma
Bewegungsschmerzen
Ruheschmerzen
Behandlung bisher

Schmerzen seit wann
Röntgen
Schmerzen wo