Magnetic resonance questionnaire

- ❒ Sede ORBV Bellinzona Tel. 091 811 86 54/55
- ❒ Sede OBV Mendrisio Tel. 091 811 32 54
- ❒ Sede ODL Locarno Tel. 091 811 46 28
- ❒ Sede ORL Lugano Tel. 091 811 60 91

First Name: ……..

Last name: ……..

Date of birth: ……..

Dear Patient,

You will undergo an MR exam.

You will be invited to take off your clothes and all removable objects: dentures, hearing aids, hairpins, glasses, contact lenses, jewellery, watches, wallets and coins, credit cards, keys, belts, clothing with metal parts, piercing, etc.

During the examination it is very important to stay immobile on the table in order to ensure the quality of the imagines taken. You will hear a rhythmic sound due to the MR scan operating.

A continuous contact between you and the radiographers will be assured during the entire procedure.

The exam's duration may vary from 20 to 60 minutes, depending on the area to be examined.

Sometimes an intravenous injection of a contrast fluid might be necessary.

We kindly ask you to complete the questionnaire on the back.

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Questo documento sostituisce il modulo EOC_M-RX-004_EN emesso il 13.10.2015

Data di revisione 05.10.2023

Please mark with a cross the corresponding answer:

Have you already had an RM exam? If so, in which hospital was the exam performed? ……	☐ YES	☐ NO
Do you have any implant in your body?	☐ YES	☐ NO
- Do you now have or have you ever had a pacemaker or defibrillator	☐ YES	☐ NO
- Artificial heart valves	☐ YES	☐ NO
- Cardiac stent, vascular stent or Bypass (year of surgery ……)	☐ YES	☐ NO
- An endoprosthesis of the aorta (thoracic or abdominal)	☐ YES	☐ NO
- Do you now have or have you ever had electrical neuro-stimulator	☐ YES	☐ NO
- Cerebral clips (year of surgery ……)	☐ YES	☐ NO
- Derivation valves (Shunt)	☐ YES	☐ NO
- Insulin implanted pumps, micro-infusers and/or sensors for diabetes	☐ YES	☐ NO
- Orthopaedic prosthesis, surgical plates or clips	☐ YES	☐ NO
- Any other medical devices	☐ YES	☐ NO
- Any metallic items in your body or metal splinters of any type	☐ YES	☐ NO
- Dental prosthesis or appliances	☐ YES	☐ NO
- Hearing aids	☐ YES	☐ NO
- Implants in the inner ear (eg. a cochlear implant)	☐ YES	☐ NO
- Contact lents, eye prostheses or implants	☐ YES	☐ NO
- Piercing, tattoos, tattooed make-up, medicated plaster	☐ YES	☐ NO
History of prior surgery? Which? ……	☐ YES	☐ NO
Specifically, have you ever had surgery?	☐ YES	☐ NO
History of kidney problems/disorders?	☐ YES	☐ NO
Do you have diabetes or glaucoma?	☐ YES	☐ NO
Do you have allergies? If so, which ones? ……	☐ YES	☐ NO
Are you claustrophobic?	☐ YES	☐ NO
Your body weight : …… Height? ……		
For women:		
Are you now or could you be pregnant? Date of last menstruation……	☐ YES	☐ NO
Do you have a breast implant?	☐ YES	☐ NO
Do you have an intrauterine device (eg. a contraceptive coil)?	☐ YES	☐ NO

I confirm that I have read the above information and that my answers are correct to the best of my knowledge. I have had the opportunity to ask questions regarding the MR exam and I give my consent for the exam execution.

Date: …… **Patient's** signature (or signature of parent or guardian): ……	Data: …… Nome e cognome o timbro del **medico che ha compilato il questionario***: ……	Data: …… Nome e cognome del **Tecnico di Radiologia**: ……

***** Solo nel caso in cui il paziente o il suo rappresentante legale/terapeutico non abbiano potuto compilare personalmente il questionario. Il medico ha compilato il questionario sulla base delle informazioni disponibili nella cartella clinica del paziente e delle informazioni fornite dal paziente (o rappresentante legale/terapeutico).