Patientenaufklärung / Englisch MRI

Magnetic Resonance Imaging – Instructions for the Patient / Questionnaire

1. When entering the changing room, please remove watch and jewelry (e.g. necklaces, earrings and rings), hairpins, clips, hearing aids and/or glasses. All your personal belongings are kept safe.
2. Remove all dentures, false teeth and partial dental plates.
3. Remove body piercing(s).
4. Remove all clothing, leave on your underwear and dress with clothing provided.
5. You are asked to use the earplugs or headphones provided during the MRI since this may affect your hearing and some patients might find the noise level unacceptable.

Please read and answer the following questions carefully. It is very important for us to know if there are any **metal devices** or **metal parts** anywhere in or on the body. If you have any question, do not hesitate to ask. If the answer to any question is **yes**, please contact us.

Surname _____ **First name** _____ **Date of birth** _____

Height (cm) _____ **Weight (kg)** _____ **Profession** _____

1. Do you have a cardiac pacemaker, nerve stimulator or any other medical implant which cannot be removed? *Sind Sie Träger eines Herzschrittmachers oder. Neurostimulators oder haben Sie ein medizinisches Gerät im oder am Körper?*..... ☐ Yes ☐ No
2. Do you have removable dentures (complete or partial) or false teeth? ..... ☐ Yes ☐ No
   Tragen Sie eine herausnehmbare Zahnprothese?
   If so, are they attached with magnets? *Wird sie mit Magneten befestigt?*..... ☐ Yes ☐ No
3. Do you have metal parts in any part of your body (e.g. joints, stents, plates, pins, screws, nails, body piercing or clips) *Befinden sich in Ihrem Körper Metallteile*..... ☐ Yes ☐ No
   z.B. Gelenksprothese, Platten, Schrauben, Nägel, Piercing, Metallclips?
   Do you have any tattoos? *Haben Sie Tatoos?*..... ☐ Yes ☐ No
4. Do/did you have any metal particles in your head, eyes or skin? ..... ☐ Yes ☐ No
   Hatten Sie früher eine Metallsplitterverletzung am Kopf, Auge oder Haut?
   If so, have they been removed by a doctor? ..... ☐ Yes ☐ No
   Wurde jemals ein Metallsplitter entfernt?
5. Have you ever had any heart or head surgery?..... ☐ Yes ☐ No
   Sind Sie an Herz oder Kopf operiert worden?
6. Do you use a hearing aid? ..... ☐ Yes ☐ No
   Tragen Sie ein Hörgerät?
7. Do you have claustophobia?..... ☐ Yes ☐ No
   Leiden Sie unter Platzangst?
8. Do you suffer from any allergies or intolerances? If so, which ones?..... ☐ Yes ☐ No
   _____
   Ist bei Ihnen eine Unverträglichkeit/Allergie bekannt? Wenn ja, welche? .....
9. Do you have an infectious disease (Hepatitis, HIV+, TBC). If so, which one? ☐ Yes ☐ No
   _____
   Ist eine Infektionskrankheit bei Ihnen bekannt (Hepatitis,HIV+,TBC)? Wenn ja, welche?.....
10. Are you wearing any medical plaster? ..... ☐ Yes ☐ No
    Tragen Sie medizinische Pflaster?
11. Do you think there is any possibility that you might be pregnant?..... ☐ Yes ☐ No
    Sind Sie schwanger?

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.
With my signature, I give my consent for the Zuger Kantonsspital to obtain necessary medical information and image files from hospitals, radiology institutes and doctors involved in my treatment and to forward them to them.

Date _____ **Signature** _____

☐ The form was filled in by a representative: _____