RADIOLOGY CLINIC OF TARTU UNIVERSITY HOSPITAL Magnetic Resonance Imaging

You are going to be examined in magnetic resonance imaging (MRI). Please read this paper carefully



Registration: 731 8377

and answer the	questions.				
NAME:					
ID:					
Body weight:	kg	Height:	cm		
MRI does not u	se any radiation.				
During the study, images will be obtained by a strong magnetic field. At the time of the examination you will have to lie motionless for about 15-60 minutes, according to the region of interest ordered by your doctor. Each movement will affect the quality of the images, which could influence the accuracy of the result of the examination.					
During the examination, the MRI machine will make noises of different volumes and you will be given headphones to protect your hearing. Contrast agent will be injected into the vein if it is necessary to acquire more information about certain symptoms. MRI contrast agent does not contain iodine and is easily tolerable.					
Please answer	the questions:				
Have you had any previous surgical procedures or operations:			□ Yes	\square No	
Have you had a	ny eye injuries (involving any n	netallic objects):	□ Yes	\square No	
Have you had i	implanted/installed:				
Any blood vess	el (artery or vein) clips, staples	etc?	□ Yes	\square No	
A pacemaker (heart stimulaator, ICD)?			□ Yes	\square No	
An insulin (or other infusion) pump			□ Yes	\square No	
Any electrodes or wires?			\square Yes	\square No	
Any joint or bone metallic prosthetics (screws, wires, plates)?		wires, plates)?	\square Yes	\square No	
Any metallic parts or foreign objects in your body?			\square Yes	\square No	
Any tattoos or permanent makeup?			\square Yes	\square No	
Any hearing aid accessories?			\square Yes	\square No	
Any other electronic implant or device?		□ Yes	\square No		

Please see reverse \rightarrow

Do you use:			
Antidepressants?		□ Yes	\square No
Allergy medication?		□ Yes	\square No
Any antiarrhythmic medication?		\square Yes	\square No
Do you have:			
Claustrophobia (the fear of small space	□ Yes	\square No	
Any involuntary movements, muscle sp	\square Yes	\square No	
Any renal diseases or kidney failure?		□ Yes	\square No
If it is necessary I agree to have cont	□ Yes	\square No	
Question for women only:			
Are you pregnant?	\Box Yes \Box	No □ N	Maybe
When was your last menstruation?	□	🗆 I	Oon't remember
Are you using hormone replacement th	erapy (women in postmeno	pause)? Yes	\square No
NB!			
Before entering the MRI examinat			
metal including hearing aids, de magnetic cards, coins etc. Remove			
in a lockable changing booth.	tumgs and po	ersonal belongn	igs can be stored
Herewith I confirm that I have read	this document and fully u	nderstood its cor	ntents.
This questionnaire has been filled by:			
\Box the patient \Box the patient's relative	treating physician	□ other medical	worker
Person completing this form:			
Signature:			••••
Date:			