DECLARATION FOR MAGNETIC RESONANCE (MRI) EXAMINATION

Semmelweis University Department of Radiology
MRI Laboratory
Director: Professor Viktor Bérczi, M.D., Ph.D., D.Sc.
Chief medical officer: Ildikó Kalina, M.D.
Address: 1082 Budapest, VIII. Üllői út 78.
Tel.: 06-1 459-1500/53171

(Please, fill out with capital letters!)

Patient name:	TAJ number (If you have):
Birthdate:	Weight (kg):

(Please, underline the correct answer!)

Do you have aneurysm clips, cochlear implants, pacemaker, artificial heart valve, intravascular stent? ..... YES.....NO

Do you have any type of metal fragment or particles in your eyes? ..... YES.....NO

Do you have any type of orthopedic implants (e.g. angles, screws,…)? ..... YES.....No

Do you have removable denture or body piercing? ..... YES.....NO

Do you or have you ever had any type of infectious disease (e.g. Hepatitis, AIDS)? ..... YES.....NO

Do you have any type of drug allergy, metal allergy? ..... YES.....NO

If yes, then what type of? .....

Have you ever previously received an intravenous contrast agent on MRI examination? ..... YES.....NO

If yes, did you have any adverse reactions? ..... YES.....NO

Is there a chance of pregnancy or are you currently breast feeding? ..... YES.....NO

Do you have kidney disease? ..... YES.....NO

Declaration of using contrast agent **(Please, underline your decision!)**

* If necessary, **I AGREE** to get intravenous contrast agent to ensure more accurate and reliable examination results.

* **I DO NOT AGREE** to get intravenous contrast agent. I understand, that if i do not agree to use contrast agent, the radiologist and the medical doctor can not be held responsible for the negative consequences of the investigation.

Date: ……/……/..... Signature: _____

(Please, read the next page for patient information guide!)