RMN EXAM

INFORMATION AND QUESTIONNAIRE FOR THE PATIENT AND FOR THE ACCOMPANYING PERSON (IF ANY)

Kindly answer to all the questions and sign the form as free and informed agreement for the exam execution.
Si

Dear patient Mr./Mrs. Surname e Name Born in on the

It has been suggested to you to execute RMN exam. In the questionnaire, there are questions about your health, in order to perform the exam safely.
This method does not use x-rays, but magnetic field (magnetic field) e radio frequency. It is not dangerous for the human body. It is important to understand that it uses a magnetic field that exercises (as a magnet) attractive forces on magnetized metal materials that you may have with you or in that you may have with you or in our body, like surgical implants, metallic splinters, IUDs, pace-makers o similar.
That's why we ask you to give detailed information to the staff about that materials.
During the exam, you will hear a rhythmic noise, coming from the equipment; the exam is not painful nor dangerous.
It is important that during the exam (that can take from 25 to 50 minutes according to the type of exam), you stay fixed, regularly breathing; you can speak in any moment with the operator.

IN ORDER TO SAFELY EXECUTE THE EXAM, YOU MUST:

- **Keep off all metallic objects** (clasps for hair, glasses, jewels, pens, watches, credit cards or magnetic supports, coins, dresses with zippers and/or buttons and/or metallic hooks, belts, etc.);
- **Keep off devices** (hearing devices, dentures, temporary teeth devices, sanitary belt, contact lenses...);
- Keep clean and dry skin, without creams or make-up, particularly in the eyes;
- **Wear only "cotton" underwear;**
- **Bring all previous documents** (clinical, laboratory, radiological) connected with the exam

Attention: the exam can ruin tattoos, if any. Clinic Direction does not bear about possible damages to the material of which the removal has been recommended.

Staff is available for any questions: please feel free to ask for any doubts before doing the exam.

WE KINDLY ASK YOU TO CAREFULLYANSWER TO THE FOLLOWING QUESTIONS:

• You suffered surgical intervention on:	□ head □ extremity	□ abdomen □ breast	□ neck □ other
Do you have:			
• **Cardiac Pace-maker or other cardiac catheters?**			□ **YES** □ **NO**
• **Defibrillatori impiantati?**			□ **YES** □ **NO**
• **Spinal or ventricular derivation?**			□ **YES** □ **NO**
• **Neuro-enhancers, brain implanted electrodes, subdural-enhancers or similar?**			□ **YES** □ **NO**
• **Spinal or ventricular catheters (in patients with hydrocephalus)?**			□ **YES** □ **NO**
• **Do you know if you have sickle cell anemia?**			□ **YES** □ **NO**
• Metallic implants (previous fractures, corrective measures, etc.) like screws, nails, strings…			□ YES □ NO
• Metallic clips on aneurysms (blood vessels), aorta, brain?			□ YES □ NO
• Hearth valves? Stents?			□ YES □ NO
• Spine implants?			□ YES □ NO
• Insulin infusion pump or other drugs?			□ YES □ NO
• Metallic objects inside ears or hearing implants?			□ YES □ NO

- IUDs? ☐ YES ☐ NO
- Fiex or mobile teeth prothesis? ☐ YES ☐ NO
- Piercing? ☐ YES ☐ NO
- Lens implant? ☐ YES ☐ NO
- Contact lenses? ☐ YES ☐ NO
- Transdermal patches? ☐ YES ☐ NO
- Metal splinters or fragments (in particular into the eyes) because of car or hunting accidents, or explosions or work-related. ☐ YES ☐ NO
- Are you breast- feeding? ☐ YES ☐ NO
- Are you claustrophobic? ☐ YES ☐ NO
- Are you suffering or did you ever suffer from seizures? ☐ YES ☐ NO
- Are you pregnant? ☐ YES ☐NO Last period date _____
- Have you ever been to vertebral-bone marrow Surgery Unit of Udine or do you think to go to? ☐ YES ☐ NO

I sincerely answered to the questionnaire, I read and understood the above mentioned and all my doubts have been cleared.
I am aware of the possibility of revoking the agreement in any moment before the exam.

I patient, Surname and Name

Or

myself, (surname name) _____born in _____on the _____ / _____ /_____

[ ] holding parental rights on the minor [ ] Tutor [ ] support administrator [ ] legal representative

Received and understood the disclosure on the exam, including methodology, term, conditions, limits and results of the exam;

Confirmed to have understood the explanations received and clarified all my doubts with the radiologist, who clearly answered;

aware of the possibility to revoke the present agreement any time before the exam.

[ ] AGREE **[ ] DO NOT AGREE**

To the execution of the above-mentioned exam

Tricesimo, ……

Signature ……

The radiologist Dr. Degano Gian Paolo ……

Tricesimo, Data

The medical responsbile of the performance
Firma ……

[ ] Dr. Degano Gian Paolo
[ ] Dr. Fiore Daniele
[ ] Dr. Ulcigrai Veronica
[ ] Dr. Rositani Pasquale
[ ] Dr. Dalla Pasqua Francesco

AGREEMENT REVOCATION

I _____

born in _____ on the_____/_____/_____

REVOKE the agreement given on the _____ to the execution of the above-mentioned exam

Tricesimo, ……

Signature ……

The radiologist responsible ……