MRI EXAMS

INFORMATION SHEET FOR THE PATIENT AND THE COMPANION

Please answer the questions below and sign the form set out as a free and informed consent for the execution of the test.

Dear Mr/Mrs:

Affix the label with patient data

In this questionnaire, you will find questions about your state of health, in order to grant you the execution of the MRI safely.
This method of investigation does not use ionizing radiation (x rays).
It is important to know that it uses an intense magnetic field that exerts (like a magnet) attractive forces on ferromagnetic materials that you may have with you or in your body, such as, for example, surgical implants, metal chips, intrauterine device, pacemaker or similar.
You must to inform the staff about that.

During the examination you can hear a swish, due to the smooth operation of the equipment neither painful nor uncomfortable.
It is important that during the examination (which may last from 25 to 50 minutes depending on the type of investigation), you remain as still as possible, breathing regularly; you can communicate with the operator at any time.

IN ORDER TO EXECUTE THE MRI EXAMS SAFELY YOU SHOULD:

- Remove all metal objects (hair clips, sunglasses, jewellery, pens, watches, credit cards or other magnetic media, coins, clothing with zippers and / or buttons and / or metal hooks, belts, etc.).
- Clean and dry the skin well, without residual creams or makeup, especially in the eyes; Wear underwear "cotton";
- Bring all previous documentation (clinical, laboratory and radiology) inherent in the examination.
- Warning: the test can ruin the tattoo may be present on the skin.

The staff is available to supplement the information contained herein, please forward to any questions y. Thank you for your cooperation.

Signature of the patient
In case of minor, kindly indicate name and surname of the parents or of those who exercite the parental authority.
In case of incapacity of consent, kindly indicate name and surname of the legal representative.

(Please attached documents certifying the role of guardian/legal representative)

MRI SCAN PRELIMINARY QUESTIONAIRE

The Magnetic Resonance Imaging technique is a risk-free test using magnetic field and radio-frequency waves. In particular circumstances may produce adverse reactions.
It is therefore of paramount importance that the following information and questioning are read and answed thoroughly and correctly. Finally, all patients are kindly requested to sign the overleaf page for given consent.

- Have you ever undergo major surgery: □ ABDOMEN □ HEAD □ THORAX
  If yes kindly specify □ ENDS □ NECK □ OTHER PARTS
- Do you have Pace-Maker? □YES □ NO
- Do you have any cardioverter defibrillator? □YES □ NO
- Do you have spinal tap or ventricular? □ YES □ NO
- Do you have spinal catheter or ventricular? □ YES □ NO
- Have you ever had sickle cell anaemia? □ YES □ NO
- Do you have metal joints/joint replacement, pins, plates, rods, screws, nails or clips? □ YES □ NO
- Do you have clips, staples of aneurysms (bloods vessels)? □ YES □ NO
- Do you have any artificial heart valve? Stents? □ YES □ NO
- Do you have any prosthesis of the spine? □ YES □ NO
- Do you have any implanted infusion or drug pump? □ YES □ NO
- Do you have dentures ,dental plate, hearing aid, ocular (eye) or cochlear (ear) implant? □ YES □ NO
- If female, do you wear an intra-uterine contraceptive? □ YES □ NO
- Are you pregnant? □ YES □ NO □ DATE OF LAST MENSTRUAL PERIOD _____
- Are you breastfeeding? □ YES □ NO
- Do you have transdermal patches? □ YES □ NO
- Do you have any piercing or tattoo in your body? □ YES □ NO
- Do you wear contact lenses or do you have prosthetic lens? □ YES □ NO
- Are you claustrophobic? □ YES □ NO
- Have you ever suffered from seizures? □ YES □ NO
- Have you ever had shrapnel or metal fragments (in particular in the eyes) due to road/hunting accidents Or following explosions caused by work? □ YES □ NO
- Are you followed by the Surgery Department of Vertebro-Medullary of Udine or do you intend to be followed by them? □ YES □ NO

Ensuring that I have answered and fully understood I give my informed consent to the execution of the exam.

THE CHIEF RADIOLOGIST

( ) Dr. Degano Gian Paolo

( ) Dr. Fiore Daniele

( ) Dr. Rositani Pasquale

( ) Dr. Dalla Pasqua Francesco

IN CAPITAL LETTERS: name and surname of the patient and/or the companion

_____

SIGNATURE patient and/or companion

_____

In case of minor, kindly indicate name and surname of the parents or of those who exercite the parental authority.
In case of incapacity of consent, kindly indicate name and surname of the legal representative.

MRI EXAMS CONTRAST STATEMENT

The undersigned

_____

Born on the

_____

Affix the label with patient data

I DECLARE THAT

I had complete information by the referring Doctor about the MRI test with contrast media.
I have read all the information above and below and I am aware about the risks and benefits of undergoing an MRI examination with the perfusion of intravenous contrast as explained in his notes.
I understand that I can freely decide to give up the investigation and eventually chose another kind of examination to reach a complete diagnosis.

Tricesimo: _____

Signature of the patient.
In case of minor, kindly indicate name and surname of the parents or of those who exercite the parental authority.
In case of incapacity of consent, kindly indicate name and surname of the legal representative.

(Please attached documents certifying the role of guardian/legal representative)

Signature of the Chief Radiologist

MRI CONTRAST INFORMATION NOTE

Your referring doctor has decided to propose you to undergo to an MRI exam with the perfusion of paramagnetic contrast agent intravenously.
This test uses magnetic fields and radio frequency (does not use ionizing radiation X-rays).
This test is performed in order to better understand your clinical problem and treat it with the most appropriate therapy.
The examination provides for the perfusion of the paramagnetic contrast agent through the portal vein of an arm.
Contrast agents currently used are extremely safe, however, may occasionally cause adverse reactions such as:

- **COMMON REACTIONS:** (1 in 100 patients – MINOR REACTIONS) Hot flashes, sneezing, nausea, vomiting, urticaria limited.
  These symptoms usually do not require any medical therapy and resolved rapidly.

- **RARE REACTIONS**: (1 in 10,000 patients – SEVERE REACTIONS) urticaria, difficulty breathing, irregular heartbeat, convulsions or unconsciousness.
  These reactions usually require medical treatment.

- **VERY RARE REACTIONS:** (from 1case in 100,000 to 1 case in 1,000,000 cases of patients) and only in extremely rare cases in patients with severe renal failure and dialysis have been reported that NSF affects mainly the legs with possibility of permanent disability.

- **UNUSUAL REACTIONS**: (1 in 5,000,000 patients - RISK OF DEATH) Very rarely, as happens with many drugs, contrast can cause death.

NB: It is interesting to know, to get a more concrete perception of risk values, the possibility of death due to car accident is 1 in 10,000.

THE PATIENT MUST INFORM ABOUT risk factors for anaphylactic reactions such as: previous reactions to contrast agent, asthma, important and full-blown allergies.
In these cases pharmacological prophylaxis is necessary before the examination.

Mr./Mrs _____ declares to have been fully informed about the exam being performed, the possible risks and consequences that may result from it.
I confirm that I understand the explanations that you have been given (information sheet) and therefore I consent to undergo this procedure.

THE CHIEF RADIOLOGIST

( ) Dr. Degano Gian Paolo

( ) Dr. Fiore Daniele

( ) Dr. Rositani Pasquale

( ) Dr. Del Zotto Aligi

( ) Dr. Dalla Pasqua Francesco

IN CAPITAL LETTERS: name and surname of the patient and/or the companion

_____

SIGNATURE patient and/or companion

_____

In case of minor, kindly indicate name and surname of the parents or of those who exercite the parental authority.
In case of incapacity of consent, kindly indicate name and surname of the legal representative.

PROPHYLAXIS
TO MAKE ONLY IN THE PRESENCE OF RISK FACTORS

(previous reactions to contrast media, asthma, allergies and major failures)

Desensitization therapy Recommended by the Medical of Padova	**Last night**	**Morning of the exam**
Methylprednisolone (Medrol) 16 mg cps	2 cps (12 h before)	2 cps (2 h before)

NOTE: If oral therapy is not possible, you can administered 100 mg of hydrocortisone (eg FLEBOCORTID) EV. 50 mg 12 hours before the exam and 50 mg 1 hour before the examination.

Pharmacological prophylaxis CANNOT GRANT the possible occurrence of adverse reactions LIGHT OR SERIOUS as well.

REMINDER

FOR MRI WITH LIQUID CONTRAST

PREPARATION OF THE PATIENT

Fasting for at least 6 (six) hours, you can take medication in case of medical therapy.

In the hours before the test we advised you to drink ½ to 1 liter of water.

BEFORE THE TEST THE PATIENT SHOULD SHOW

1. A medical prescription of the referring doctor/specialist including a concise clinical relationship with the diagnostic problem (see appendix)
2. Health care card;
3. Possible medical records, previous laboratory and radiological investigation;
4. Compilation of informed consent;
5. Compilation of the questionnaire;
6. creatinine (recent blood test).

The patient will be contacted by the health care facility a few days before the exam to check the documentation.
In case of cancellation of the exam, in order to allow access to other users waiting for the same exam, please let us know as soon as possible by calling the No 0432.854123 0432.851321.

We trust into the courtesy of the referring Doctor to check the truly of the statement by the patient in the following questionnaire; this is to ensure maximum safety for your patient in the perfusion of contrast.

ANAMNESTIC FITTING

RADIOLOGICAL DIAGNOSIS WITH CONTRAST INJECTED

(Ministerial Circular 17.09.1997)

The anamnestic and clinical evaluation for Mr./Mrs. _____

For whom I porpose the investigation of _____

- □ On the proposal of _____
- □ For the following clinical reasons: _____

  _____
- □ In the suspected diagnosis of: _____

  _____

Is

( ) **NEGATIVE for**: certain risk of allergic to iodine or other substance and iodinate contrast, severe hepatic, renal or cardiovascular paraproteinaemia of Waldestrom or multiple myeloma.
Therefore, there are no contraindications to the use of paramagnetic organoid contrast injection.

( ) **POSITIVE for:**

( ) Demonstrated allergic risk to iodinated contrast or other substances
( ) Severe hepatic impairment
( ) Severe renal impairment
( ) Serious cardiovascular insufficiency
( ) Paraproteinemia of Waldestrom
( ) Diabetes
( ) Multiple Myeloma
( ) Thyrotoxicosis

Attachment: laboratory tests and diagnostic reports that define the degree of pathological conditions.

Creatinine (value mg / dl) _____ _____ Date (no more than 90 days) (always carry a copy of the examination or the original exam).

The patient is currently receiving the following nephrotoxic drugs suspended from 24 to 48 hours:

( ) Cyclosporine (Sandimmun), ( ) cisplatin (citoplatino etc.), ( ) interleukin 2
( ) Nephrotoxic antibiotics (BB-K8, gentalyn, nebicina)
( ) Beta blockers (atenolol, Dilatrend, Inderal, Lopresor, seloken, seles beta sotalex, Tenormin, Trandate, visken, etc..)
( ) Diuretics (aldactone, igroton, kanrenol, lasix, etc..)
( ) Painkillers or FANS (aspirin, Aulin, Feldene, Moment, metacen, Oki, Synflex, Toradol, Voltaren, etc.)
( ) Biguanides (metformin)

In case of impossibility to temporarily suspend such therapies tick the box ( ).

( )Performed a premedication for allergic risks with: _____

The Referring Doctor

(Stamp and Signature of the Doctor)