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|  | **Informed consent to diagnostic/treatment procedure**  **MAGNETIC RESONANCE** |

**PATIENT´S NAME AND SURNAME:…................................................................................................................................................... personal id: .............................................................................................................. weight:............................................... (kg) telephone number: ...........................................................................** **HEALTH INSURANCE COMPANY: ................................**  
 IMPORTANT: **INFORM THE STAFF IN CASE YOU HAVE A CARDIOSTIMULATOR (pacemaker)!!!   
 IN THAT CASE, YOU MUST NOT UNDERGO A MAGNETIC RESONANCE EXAMINATION!!!**

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| Please, carefully mark the correct answers with a cross!!! |

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| Have you ever undergone an MR examination? | □ YES | □ NO | → | If yes, specify when or the facility where the examination was performed. |  | |
| Cardiostimulator / myostimulator / neurostimulator | □ YES | □ NO |  | Cochlear implant (hearing aid) | □ YES | □ NO |
| Implantable cardioverter-defibrillator / ICD | □ YES | □ NO |  | Metal shavings in your eye | □ YES | □ NO |
| Insulin pump | □ YES | □ NO |  | Metal shavings, splinters or shrapnels elsewhere in your body | □ YES | □ NO |
| Artificial heart valve | □ YES | □ NO |  | Ocular prosthesis / artificial lens | □ YES | □ NO |
| Implanted stents  (vascular reinforcement), blood vessel clips, clamps etc. | □ YES | □ NO | → | If yes, specify when and where. |  | |
| Artificial joint replacement | □ YES | □ NO | → | If yes, specify when and where. |  | |
| Metal spinal implants | □ YES | □ NO | → | If yes, specify when and where. |  | |
| Removable dental prosthesis (Do not mention dental fillings and implants!) | □ YES | □ NO |  | Impaired kidney function | □ YES | □ NO |
| Dental braces, retainers after removal of braces | □ YES | □ NO |  | Colostomy (opening in the large intestine) | □ YES | □ NO |
| Permanent make-up | □ YES | □ NO |  | Glaucoma | □ YES | □ NO |
| Tattoo | □ YES | □ NO |  | Claustrophobia (fear of confined spaces) | □ YES | □ NO |
| Allergy (food, drug, pollen) | □ YES | □ NO | → | If yes, please, specify. |  | |
| Have you ever been administered a contrast medium during an examination? | □ YES | □ NO | → | If yes, did you feel any discomfort, e.g. itching, shortage of breath, dizziness or collapse? | □ YES | □ NO |
| **For women:** Are you pregnant? | □ YES | □ NO |  | Do you breast-feed? | □ YES | □ NO |
| **Warning:** Permanent dental prostheses are not contraindicated for MR examination. Prior to an MR examination, please, remove removable dental prostheses, jewellery, watches, glasses, piercings and any other metal objects! It is recommended that you do not put on make-up before an MR examination in the head area. Do not bring any valuables and weapons for an MR examination! Please, follow the instruction of the staff. Thank you. | | | | | | |

*Thank you for filling in the form carefully.*

Dear Madam, Dear Sir, Dear parents. Your doctor has recommended you a magnetic resonance (MR) examination based on your health condition. It is a diagnostic imaging method used to examine most organs of the human body. The examination is not based on the principle of X-rays. The strong magnetic field and radiofrequency energy used in MR examinations have not yet been proven to have harmful biological effects. Nevertheless, we prefer to avoid examining pregnant women in the first three months of pregnancy. Your consent is required to perform the proposed examination. In order to facilitate making your decision, we would like to provide you with the following information.

**Aim and nature of diagnostic/treatment procedure:**

The aim of examination is to show the examined body part in detail according to the requirements of the attending physician. During an MR scan you lie in a tunnel. You must lie still. The examination usually takes approximately 20 – 45 minutes. Contrast medium may be administered intravenously during the examination. You may feel a stinging sensation in your vein, followed by a „administration“ sensation, which is normal. The contrast medium improves the evaluation of pathological processes in the examined area. A radiologist decides about the suitability of the contrast medium application. The contrast medium is safe, but as with any other drugs, side effects may occur occasionally (such as nausea, discomfort in the injection site, headache). Our medical staff is trained to handle any possible adverse situations. A radiologist evaluates the pictures taken. The examination description will be sent to your physician.

**Advantages and disadvantages of MR examination**

Advantages: very accurate imaging of human body parts without radiation exposure.

Disadvantages: cannot be performed in patients with a cardiostimulator (pacemaker), myostimulator or neurostimulator. Metal objects (joint replacements, stents, vascular clamps, etc.) anywhere in the body may affect the quality of the final images. The examination is contraindicated in female patients in the first trimester of pregnancy. Considerable noise made by the MR equipment. For this reason, the health care facility staff will offer you hearing protection, such as headphones or disposable earplugs.

**Other (alternative) options for diagnostic procedure, including its advantages and disadvantages**

Ultrasound /sonographic examination/ – well accessible, no radiation exposure, but lower examination accuracy

CT – worse evaluation of subtle pathological changes, radiation exposure during examination, often necessary to administer iodine contrast medium with a risk of allergic reaction

**Possible risks and complicating conditions**

During the examination, a so-called panic attack, i.e. fear of confined spaces, anxiety, distress, discomfort, may occur. You can report any problems to the examining staff by pressing a push button that you hold during a MR examination. The staff will acute with an acute problem immediately and is able to get you out of the tunnel in a few seconds.

An examination in patients with an implanted cardiostimulator (pacemaker), myostimulator, neurostimulator or any other extraneous metal object may lead to serious damage to your body or death!!! Orthopaedic splints and joint replacements are not obstacles to the examination after a certain period after the implantation.

**Additional information: No restrictions after examination**

If contrast medium has been administered, it will be eliminated from your body within 24 hours. Breastfeeding women are recommended not to breastfeed during this time. During a MR examination of the abdomen and pelvis you will be administered a so-called spasmolytic intravenously. It slows down the movement of intestines and improves the imaging quality, but may cause temporary blurred vision. This effect disappears within several minutes. In case you experience this effect, you should not drive. CAUTION! – Spasmolytic must not be administered to patients with glaucoma. In case other drugs are administered, you will be instructed by the MR facility staff.

**Information for patient (patient´s legal representative)**

* Please, read carefully all pages of this informed consent.
* In case you have not fully understood the information in this informed consent or you need any additional information, do not hesitate to ask the MR facility staff.

*Please, continue by filling in the data on the next page.*

**Declaration:**

I, the undersigned,

hereby declare that I have been clearly informed about the purpose, nature, expected benefits, possible consequences and risks associated with MR examination and other possibilities of providing health services and their suitability, benefits and risks. I had an opportunity to ask additional questions and, if so, all my questions were answered. I fully understood all provided information. I am fully aware of the fact that I have the right to a second opinion. Based on this instruction and at my own discretion, I willingly and without coercion give my consent to:

- the above-mentioned diagnostic procedure – MR examination;

- the administration of a contrast medium if required by MR examination

I further declare that

* I do not have a cardiostimulator (pacemaker), myostimulator, neurostimulator or any extraneous metal object other than orthopaedic splints or joint replacement in my body;
* I have answered the above questions truthfully;
* I have not withheld any known data about my health condition;
* I have not concealed any other significant circumstance that would prevent MR examination from being performed; and
* I acknowledge that I may disclaim the provision of information about my health condition or that I may specify which person should be provided with this information or that I may prohibit the provision of information about my health condition to a certain person or to any person.

I further declare that I am insured in the above-mentioned health insurance company. If this is not the case, I undertake to compensate for the damage incurred by the health care facility.

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| Do you wish to have visual documentation from MR examination on a CD / DVD prepared for a fee of CZK [complete]? | □ YES | □ NO |

**In Prague, on:** ....................................

**Patient´s signature**: ................................................

**Signature of the health worker who provided the instructions and checked the answered questions:** ................................................

*In case the patient is not able to sign, the signature of the witness who was present at the expression of the consent:*

Witness’ name and surname: ................................................

Reason for not signing the consent: ................................................

Way of expressing the patient´s will: ................................................

Witness’ signature: ................................................

*In case the patient is not able to give his/her consent due to his/her health condition, the signature of the person designated by the patient, spouse or registered partner, parent or any other close person*

Name and surname: ................................................ Date of birth: ................................................

Relation to the patient: ................................................

Signature: ................................................

*Thank you for filling in the form carefully.*