

MRI pre-information form

We ask you to answer the following questions for MRI examinations.

Do you have any of the following?	YES	NO
Pacemaker, heart rhythm monitor, or related leads	<input type="checkbox"/>	<input type="checkbox"/>
Medication patch, insulin pump, or pain pump	<input type="checkbox"/>	<input type="checkbox"/>
Glucose monitor	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear implant or hearing aid	<input type="checkbox"/>	<input type="checkbox"/>
Aneurysm clips or other surgical clips, shunts	<input type="checkbox"/>	<input type="checkbox"/>
Allergy to medication, anesthetics, or contrast agents	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney failure	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant or breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>

For possible administration of contrast agent

Do you have any bloodborne infectious disease?

Has the area to be imaged been examined before?

(MRI or CT scan)

May we use your previous images for comparison?

Consent to the use of my data for targeted communication and offers

Height _____ cm Weight _____ kg

Date _____ Personal identity number _____

Signature _____ Printed name _____



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For better health