UZ LEUVEN | RADIOLOGIE

Patient questionnaire for MR examination

Your physician has requested a MR examination. For this procedure you will be exposed to a strong magnetic field.
For your own safety we ask that you complete this questionnaire as correctly and completely as possible in order to trace any possible contraindication prior to the examination.
Please bring this form with you and give it to the person in charge of the examination. If this document is not properly filled out, for your own safety, the examination cannot take place.

1. Do you have a pacemaker or an implanted defibrillator? Yes ☐ No ☐
2. Do you have an ear implant / a cochlear implant? Yes ☐ No ☐
3. Do you have an insulin or implanted pump, a neurostimulator or VP shunt? Yes ☐ No ☐
4. Do you have any metallic object in your eyes (metallic fragments) or metal elsewhere in your body (bullet, lead, shrapnel, chirurgical implants, temporary breast implant with magnetic entry)? Yes ☐ No ☐

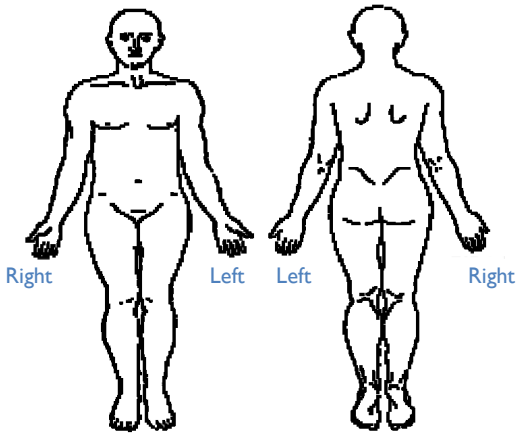
IF YOUR ANSWER IS 'YES' TO AT LEAST ONE OF THE ABOVE QUESTIONS, PLEASE CONTACT THE DEPARTMENT OF RADIOLOGY AS QUICKLY AS POSSIBLE, DURING OFFICE HOURS BY TELEPHONE 016/34 36 60.

5. In case you are diabetic and wearing a sensor sticker for glucose measurement, **please contact us at 016/34 36 59 or 016/34 36 60 for an appointment as close as possible to the day you change your sticker.**
6. In case your MR appointment is planned when you will wear an on-body injector for Neulasta (chemo therapy), **please contact us at 016/34 36 59 or 016/34 36 60 for rescheduling.**
7. Do you have a hearing aid? Yes ☐ No ☐
8. Do you have an artificial heart valve? Yes ☐ No ☐
9. Do you have a joint replacement, dental prosthesis or dentures? Yes ☐ No ☐
10. Do you have a port catheter? Yes ☐ No ☐
11. Have you ever had brain surgery? Yes ☐ No ☐
12. Have you ever had vascular surgery (blood vessel operation / blood vessel catheter?) Yes ☐ No ☐
13. Have you had an organ transplant? Yes ☐ No ☐
14. Do you have any medication or other patches on your body? Yes ☐ No ☐
15. Do you have a tattoo, (permanent) eye make-up or piercing? Yes ☐ No ☐

Please also read, complete and sign the back side/second page

16. Do you wear a wig/hair extensions or spray hair paint on bold spots? Yes ☐ No ☐
17. Are you allergic to any contrast agent? Yes ☐ No ☐
18. Are you pregnant or breastfeeding? Yes ☐ No ☐
19. Do you suffer from poorly functioning kidneys (renal insufficiency)? Yes ☐ No ☐
20. Do you have glaucoma (eye-disease)? Yes ☐ No ☐
21. Did you ever have adverse reaction on Buscopan (muscle relaxant) Yes ☐ No ☐

On this drawing you can indicate where you underwent surgery:



Please remove <u>all</u> metal objects (body piercing jewellery, jewellery) from your body and leave these in the dressing room, together with your identity card, bank cards, coins, belts, keys and cell phone.
If you have body piercing jewellery or other jewellery that cannot be removed easily, please inform the MR staff.
Golden/silver rings that are difficult to remove, may remain at your finger.

I DECLARE THAT THE ABOVE MENTIONED INFORMATION IS CORRECT ON THE DATE OF THE SCHEDULED PROCEDURE.

Patient name: ……. Height: ….. m ….. cm Weight: ….. kg

Date of birth: …….

Name (patient or parent/guardian or Physician)	Date **examination**	Signature
……...……	…. / …. / ….	……