ANAMNESTIC QUESTIONNAIRE
For MAGNETIC RESONANCE IMAGING (MRI)
AND
INFORMED CONSENT

NAME and SURNAME of PATIENT:_____ **DATE of BIRTH:** _____

☐ OUTPATIENT CLINIC ☐ ADMITTED TO THE HOSPITAL UNIT OF _____ *PATIENT'S BARCODE TAG*

The "medical history questionnaire" aims at ascertaining the absence of contraindications to the test, and must be carefully filled out and signed at the bottom by the Doctor in charge of the test who, in his assessments, makes use of the answers provided by the patient or by his legal guardian (in respect for instance of a minor).

QUESTIONNAIRE

Have you previously undergone magnetic resonance imaging (MRI) tests?	☐ yes	☐ no
Have you ever had allergic reactions to radiocontrast agents?	☐ yes	☐ no
Do you suffer from Claustrophobia?	☐ yes	☐ no

The patient is a bearer of:		
Cardiac pacemaker or other types of cardiac catheters	☐ yes	☐ no
Implanted defibrillators	☐ yes	☐ no
Heart valves or other types of cardiovascular prostheses	☐ yes	☐ no
Stents	☐ yes	☐ no
Infusion pumps for insulin or other medications	☐ yes	☐ no
Neurostimulators, electrodes implanted in the brain or subdural	☐ yes	☐ no
Other types of stimulators	☐ yes	☐ no
Clips on aortic aneurysms, brain	☐ yes	☐ no
Spinal or ventricular shunt	☐ yes	☐ no
Spinal cord distraction agents	☐ yes	☐ no
Metallic foreign bodies in the ears or hearing aids	☐ yes	☐ no
Prosthesis of the lens	☐ yes	☐ no
Fixed or removable dental prostheses	☐ yes	☐ no
Metal prostheses (previous fractures, stitches, nails, wires)	☐ yes	☐ no
Other prosthesis LOCALIZATION _____	☐ yes	☐ no
Intrauterine device (IUD)	☐ yes	☐ no
Are you pregnant? Certain or presumed?	☐ yes	☐ no
Have you undergone surgeries ☐ Head …… ☐ Neck ……. ☐ Chest …… . ☐ Abdomen ……. ☐ Limbs ……..… ☐ Eyes ……. ☐.Other……	☐ yes	☐ no
Are you aware of carrying one or more medical devices or metal parts inside your body?	☐ yes	☐ no
Have you been the victim of explosions, hunting accidents, traumas/road accidents?	☐ yes	☐ no
Have you worked as blacksmith, lathe turner, welder, body shop mechanic, preparer of metallic paints?	☐ yes	☐ no

Do you have any tattoos?	☐ si	☐ no	Localization
Do you carry any piercing?	☐ si	☐ no	Localization
Are you using any medical tapes?	☐ yes	☐ no	

PRINT ON BOTH SIDES

To carry out the MRI test, you must remove:
any contact lenses–hearing aids-dentures-temporary removable crowns-hernia support belt-hair clips-pegs-glasses-jewellery-watches-credit cards or other magnetic cards-pocket knives-money clips-coins-keys-automatic hooks-metal buttons-pins-zippered clothes-metal tweezers-nail files-scissors-any other metal objects.
Prior to undergoing the test, kindly remove cosmetics from the face.

THE DOCTOR IN CHARGE OF THE MAGNETIC RESONANCE IMAGING (MRI) TEST

Having noted the answers provided by the patient and having completed the medical examination and/or further preliminary diagnostic tests

HEREBY AUTHORIZES THE EXECUTION OF THE MRI TESTS

Signature by the doctor in charge of carrying out the MRI test Date

…… ……..

PATIENT'S BARCODE TAG
xxxx xxx xx xxx x xxxxxx

I, the undersigned_____ born in _____ on _____

Declare that I have been fully informed, through the interview with Dr/s_____

About _____ (write disease or suspected diagnosis) and:

I agree I do not agree

to undergo _____

(report diagnostic or therapeutic procedure - and specify the location/side of the operation) and a possible _____ *(write consent to other operations connected to the main one).*

In particular I have read and understood the information contained in the **Information Note**

_____*(specify code)* that was given to me and explained clearly in all its points:

- Description of the suggested treatment
- Potential benefits and disadvantages
- Possible risks and complications
- Possible alternatives
- Possible outcomes of non-treatment
- Possible recovery problems

PRINT ON BOTH SIDES

Any comments _____

I therefore freely and explicitly give my consent to the realization of the proposed treatment, aware that I can withdraw my give consent at any moment.

Date, .../...../.....

Signature of patient* **Signature of parent/s or of a person who exercises parental responsibility ****

_____ _____

Stamp and legible signature of the Physician_____

Consent achieved with the aid of an interpreter / cultural mediator: YES ☐ NO ☐

Signature of the interpreter / cultural mediator _____

Having understood what has been explained, I freely and consciously decide **NOT TO AGREE** to be subjected to the treatment described above, aware of the consequences of that decision.

Signature of the patient Signature of Physician

_____ _____

* In the case of a legally incapacitated patient the signature must be made by the guardian; in the case of an incapacitated patient, the incapacitated person must sign as his will prevails over that of the curator.
** He/she expresses the will in question also for the other parent (excepting explicit dissent by one of the parents, in which case the Tutelary Judge will have to be involved). In cases of exclusive custody, exercising parental responsibility lies with the person and / or parent to whom the child is assigned.