Questionare for MRI examination

Name:_____

Personal number (date of birth): _____

I am _____**cm tall**

I weigh _____**kg** Call MRI if you weigh more than 130 kg

<u>If you answer YES in any of the questions below or if you can not come for examination, please call</u> 0920-28 29 06.
Bring this form with you when you come for your examination.

Questions, circle your answers		
1. Do you have a pacemaker or have you had it before?	**Yes**	**No**
2. Have you had head or heart surgery? **If yes, write date and hospital** _____	**Yes**	**No**
3. Do you have metal parts in your body?	**Yes**	**No**
a) If so, what kind?_____		

Example: metal clips, valve replacement, earboneprosthetic, infusion pump, mixing valve, aortic stents, stent, nervstimula? You do not have to answer yes if you have: dentures, hip or knee replacement.

4. Have you been injured by metal splinters in the eyes?	**Yes**	**No**
a) If so, is it removed?	**Yes**	**No**
5. Do you have Diabetes or muscle disease Myasthenia gravis?	**Yes**	**No**
6. Do you use a wheelchair?	**Yes**	**No**
7. Are you pregnant or breastfeeding?	**Yes**	**No**

- If so, call us at least one week before the examination

Are you scared of being in a confined space or have a hard time to lay still? Ask your doctor for medication.

Usually the exam takes between 20-60 minutes. It is important that you can lay still the whole time, because of that it can be helpful to take some analgesics before the exam.
All loose object must be removed, for instance jewelry, piercings, hair pins, wristwatch, cell phone, hearing aid, insulin pump, blood glucose monitor, coloured contact lenses etc.
Note! If you are going to exam the brain, avoid eye makeup as this may degrade the image quality.

I certify that the information I have provided is true

Signature:_____

Date: _____

Companion at MRI

Name: _____

Personal number (date of birth):_____

1. Do you have a pacemaker or have you had it before?	**Yes**	**No**
2. Have you had head or heart surgery? **If yes, write date and hospital** _____	**Yes**	**No**
3. Do you have metal parts in your body?	**Yes**	**No**
b) If so, what kind?_____		

Example: metal clips, valve replacement, earboneprosthetic, infusion pump, mixing valve, aortic stents, stent, nervstimula? You do not have to answer yes if you have: dentures, hip or knee replacement.

4. Have you been injured by metal splinters in the eyes?	**Yes**	**No**
b) If so, is it removed?	**Yes**	**No**
7. Are you pregnant?	**Yes**	**No**

I certify that the information I have provided is true

Signature:_____

Date: _____