MRI-Patient Questionnaire

DIAGNOSTIKUM BERLIN by Evidia Group

PLEASE FILL OUT THIS FORM AND MARK THE RELEVANT INFORMATION:

Last name: **First name:** **Birth date:**
Height: **Weight:** kg **Tel:**
E-Mail:

Are there any older images of the examination area? yes (Diagnostikum) ○ yes (other provider) ○ no ○ will be given later ○

For women: Are you pregnant? yes ○ no ○
Do you breastfeed? yes ○ no ○

Do you have the following metals/implants in or on your body? yes ○ no ○

- ☐ Pacemaker
- ☐ Cochlea-Implant
- ☐ Magnet. dental prosthesis
- ☐ Metal/shrapnel
- ☐ Artificial heart valve
- ☐ Metal parts/prostheses after operations
- ☐ Insulin-/Pain pump
- ☐ Vascular clips
- ☐ Hearing-aid
- ☐ Other:

What complaints do you have in the area under examination and for how long? ☐ left ☐ right ☐ middle

Was there an accident that caused your current symptoms? yes ○ no ○
If yes, when?

Have you ever had an operation in the examination area? yes ○ no ○
If yes, which year and why?

Do you have any of the following illnesses? yes ○ no ○

- ☐ Infectious diseases — ☐ HIV ☐ Hepatitis ☐ Tuberculosis ☐ Other:
- ☐ Chronic diseases — ☐ Rheumatism ☐ Crohn's ☐ MS ☐ Other:
- ☐ Tumors/cancer diseases — Which ones? Which year? How were you treated? ☐ OP ☐ Chemotherapy ☐ Radiation therapy
- ☐ Kidney diseases — Which one?
- ☐ Allergies — Which one?

Have you had an allergic reaction to contrast media during previous examinations? yes ○ no ○

Other remarks:

Doctors signature Diagnostikum Berlin

turn over please →

☐ **My referring doctor shall receive the results of the examination.**

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Consent Declaration

By my signature, I confirm (if applicable, on behalf of the patient):

- ○ that I have read and understood the information sheet and have answered the questions regarding the medical history (patient history) to the best of my knowledge.
- ○ that I have been thoroughly informed about the planned examination. I have no further questions and feel fully informed.
- ○ that I consent to the possible administration of a contrast agent (non-iodinated, non-radioactive) by the medical assistance personnel (MTR, MFA).
- ○ that I have carefully considered my decision. I do not require any further reflection period and consent to the examination.

Doctolib

○ I hereby consent to being reminded of my appointment by Diagnostikum Berlin. By giving my consent, I agree to the processing of my ☐ mobile phone number or ☐ email address for the purpose of appointment reminders. Please note that we use Doctolib as a service provider for sending appointment reminders. This consent is given on the basis of Article 9(2)(a) in conjunction with Article 6(1)(a) and Article 7 of the GDPR.

My personal data will not be processed or transmitted for any other purposes.

○ I do **not** consent to the appointment reminder service.

Notice: Refusal of Contrast Agent Administration

I do not consent to the recommended examination with contrast agent, despite having been expressly informed about possible disadvantages due to limited diagnostic assessability.

Date, Patient signature/Authorized Representative

I hereby consent to the examination and confirm that all the information provided here is truthful and complete. I may revoke my consent to the transmission of data to my referring physician and to the appointment reminder service at any time without providing reasons. A revocation pursuant to Article 7(3) of the GDPR does not invalidate the legal basis for data processing carried out in the past. It only takes effect for the future from the moment the revocation is received.

I agree that I will NOT receive a copy of the informed consent form. yes ○ no ○

Date, Patient signature/Authorized Representative

X

Name Authorized Representative