

Examination Date: Weight: Height: Name:
 PESEL No.:

All medical information is subject to medical confidentiality and will not be used for any purpose other than medical. Please circle your response.

Have you had an MRI done before? Yes No
 If so, when?

Have you ever had an examination with a contrast or dye? Yes No

Did you experience any allergic reactions after the examination with a contrast? Yes No
 If so, what types?

Have you had any surgeries? Yes No
 If so, what types?

Have you ever had any infectious diseases (excluding during childhood years). Yes No
 If so, what types?

Please indicate whether you suffer from any of the conditions listed below:

Irregular heartbeat Yes No

Anxiety (claustrophobia) Yes No

Hypertension Yes No

Diabetes Yes No

Sudden fainting Yes No

Liver transplant Yes No

Nervous system diseases (e.g. epilepsy) Yes No

Kidney disease (e.g. kidney failure, gout) Yes No

NOTE: Metal objects in the magnetic field of the machine prevent the correct interpretation of the examination, and in some cases may constitute a medical contraindication for the examination.

Please indicate if you have any of the devices listed below in your body:

Pacemaker Yes No

Ventricular or spinal shunts Yes No

Metal seams, stents, screws Yes No

Intracranial vascular clips Yes No

Metal intrauterine devices (spirals) Yes No

Artificial heart valves Yes No

Metal filings in the eyeball Yes No

Hearing aid Yes No

Metal dental bridges Yes No

Other Yes No

If so, please list here:

Have you used any body cosmetics containing metallic components before the examination? Yes No

Do you take any medications? Yes No
 If so, which ones?

Is there anything you would like the doctor performing the MRI to know regarding your health condition? Yes No
 If so, please list here:

NOTE: FOR WOMEN ONLY
MRI examinations during pregnancy (especially in the first trimester) should be limited to life saving situations.

I CERTIFY THAT:

• I am pregnant Yes No

• I am breastfeeding Yes No

• Date of the last menstrual period:

CONSENT TO MRI EXAMINATION

INFORMATION: In individual cases, to ensure proper diagnoses, it may be necessary to administer a contrast agent intravenously, which can sometimes cause allergic reactions. The patient should immediately inform the medical personnel if he/she experiences any adverse reactions, such as: nausea, skin reactions, difficulty breathing, increased heart rate, or dizziness. In extreme cases, complications may occur, including: fainting, swelling of the face and larynx, bronchospasm, seizures, drop in blood pressure, stopping breathing, or cardiac arrest. After the examination, the patient is monitored for 30 minutes, after which the nurse will remove the cannula. The contrast agent impacts the ability to drive. Patients should not drive for an hour after the administration of the contrast agent.

STATEMENT: I certify that I was able to freely ask questions regarding the planned examination, the risks involved and the potential complications, and I received clear, thorough and understandable answers to my questions. I hereby give my informed consent after making my own decision, for which I had enough time. I also certify that all the information provided by me is true and I did not conceal any important information regarding my health, previous treatment or medications taken. I am aware of the potential consequences of such actions.

I consent to the MRI examination Yes No

I consent to the intravenous administration of a gadolinium-containing paramagnetic contrast agent. Yes No

Do you consent to having your results collected by an authorised person indicated by you, after verifying their identity? Yes No
If so, please provide the details of the authorised person (name, PESEL No.):

.....
Date Signature of patient or legal guardian

FOR PATIENTS UNDERGOING THE EXAMINATION UNDER THE NATIONAL HEALTH FUND

Were you under hospital care on the day of the examination? Yes No
.....
Date Signature of patient or legal guardian

FOR PATIENTS UNDERGOING THE EXAMINATION PRIVATELY

In the case of a private examination I hereby agree to cover the cost of the examination, i.e. PLN....., in accordance with the price list of the Medical Centre. I was informed about the total cost of the examination with the contrast agent and the method of obtaining my results.
.....
Date Signature of patient or legal guardian

CONSENT TO THE USE OF THE TELEPHONE NUMBER AND EMAIL ADDRESS

I, the undersigned, hereby conform that the phone number/email address* indicated by me below is the correct one to contact me with regards to medical services provided to me by Affidea, including sending a text message/email* containing authorisation details necessary for me to use Affidea's Patient Portal at www.affidea.pl where I can view and download my diagnostic test results.
Telephone No.: providing it is necessary for the patient to use the Patient Portal (to view test results).
Email address: providing it is not necessary for the patient to use the Patient Portal, but it will allow obtaining the authorisation details needed to use the Portal via email.
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Date Signature of patient or legal guardian