DATE .....

TIME .....

EXAMINATION NUMBER .....

RESEARCH QUESTIONNAIRE

MAGNETIC RESONANCE IMAGING

HEAD

During the examination, the patient is exposed to a strong magnetic field. A loud sound is present throughout the entire examination. The patient is required to lie still for about 30-60 minutes. It is strictly prohibited for the patient to carry any metal/electronic elements or pieces of jewelry during the examination. Our MRI laboratory takes no responsibility for their damage. Any information provided by the patient in the questionnaire is covered by personal data protection.

NAME AND SURNAME .....

DATE OF BIRTH ..... PESEL NUMBER.....

ADRESS .....

..... TELEPHONE NUMBER.....

GENDER FEMALE ☐ MALE ☐ | WEIGHT .....kg | HEIGHT ..... cm

Please select an answer. Example: YES ☒ NO ☐

Does the patient have any of the following elements in their body? (if YES, please select which ones)

- ☐ pacemaker
- ☐ artificial heart valve
- ☐ hearing aid
- ☐ metal vascular clips
- ☐ eye prosthesis
- ☐ cochlear implant
- ☐ neurostimulator
- ☐ metal filings in the eye
- ☐ insulin pump
- ☐ stents

Orthopedic implants or other: .....

☐ Is the patient pregnant?	☐ YES	☐ NO
☐ Is the patient afraid of being in tight spaces?	☐ YES	☐ NO
☐ Has the patient ever had an MRI performed? If yes, what was examined and when?	☐ YES	☐ NO
☐ Does the patient suffer from renal failure?	☐ YES	☐ NO
☐ Has the patient experienced any allergic reactions? (to drugs, contrast medium)	☐ YES	☐ NO

I consent to sending my examination results in an electronic form to my phone number:

.....

I hereby declare that I am aware of the risks associated with sending data electronically. In case of any unexpected events, I will not pursue any legal action against **REZONANS FC**.

PATIENT'S SIGNATURE .....

FACE-CLINIC NZOZ CENTRUM LECZENIA WAD ZGRYZU, **NIP** 5221871747, **REGON** 016252870

ul. Łuczek 4
02-434 Warszawa

tel. 222 139 310

rezonansfc.pl
e-mail recepcja@rezonansfc.pl

rezonans FC

HEAD EXAMINATION

Please mark any symptoms that occur:

☐ nausea/vomiting ☐ vision dysfunction ☐ headaches

others, such as: .....

Has the patient been injured? If YES, please specify when: .....

.....

Is the patient being treated by any specialists? If YES, which ones and since when: .....

.....

Does the patient suffer from any chronic diseases? If YES, which ones .....

.....

Have there been any surgeries in the area being examined? If YES, specify the date, type and extent of the operation:

.....

Has the patient experienced any allergic reactions? (to drugs, contrast medium) .....

.....

.....

Did the patient have COVID-19 infection? ☐ YES, WHEN? ..... NO ☐

Was the patient vaccinated against COVID-19? ☐ YES ☐ NO .....

If the examination with a contrast medium amplification is necessary, I agree on the intravenous injection of the contrast medium, elongation of the examination (the price of the additional payment for the contrast medium is given in the price list) ☐ YES ☐ NO

I confirm that I have read and understood the text above. I also confirm that I did not hold back any information regarding my present health condition ☐ YES ☐ NO

I consent to the MRI examination and the price given in the effective price list of REZONANS FC. I oblige to covering the cost of the examination at the reception desk after the procedure. ☐ YES ☐ NO

DATE AND PATIENT'S SIGNATURE (LEGIBLE) .....

☐ I AUTHORIZE (NAME AND SURNAME) .....

TELEPHONE NUMBER: ..... PESEL NUMBER .....

to have access to my medical records, information about my current health state and health services provided..

☐ I DO NOT AUTHORIZE anyone to have access to my medical record.

PATIENT'S SIGNATURE .....

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