

PATIENT INFORMATION AND CONSENT MAGNETIC RESONANCE IMAGING

WHAT IS MRI?

Magnetic Resonance (RM) is a diagnostic technique that does not utilize ionizing radiation or radioactive substances. MR imaging uses static magnetic fields and electromagnetic radiofrequency waves, similar to those used by radio and television.

MR imaging without contrast material is a non-invasive diagnostic test and, based on current knowledge, it does not produce important biological effects on patients for whom it is not contraindicated, and it is performed according to safety regulations and standards.

Nevertheless, it is prudent not to perform MR imaging in the first trimester of pregnancy.

WHY IS IT DONE?

MRI is used in the diagnosis of pathological conditions affecting the brain and the spine, the abdomen, the pelvis, large vessels and the musculoskeletal system (joints, bones, soft tissues).

HOW IS IT DONE?

The procedure is neither painful nor uncomfortable. The patient lies on a bed and, depending on the organ to be examined; coils (bands, helmets, plates) are placed externally on the body. They come in different shapes to adjust to the anatomical region to be examined. The coils do not cause any pain or discomfort since they are placed externally on the body with the exception of endorectal coils.

During the procedure, rhythmic noise can be heard of variable intensity. This is the normal noise produced by the scanner during the procedure.

An MRI may require the intravenous administration of a paramagnetic contrast agent.

POSSIBLE COMPLICATIONS

The procedure rarely produces mild complications such as claustrophobic sensations, itching, shortness of breath, palpitations or discomfort. Should any complication occur, the patient can alert the caregivers by pressing an alarm button that will be close at hand all through the procedure.

NECESSARY PREPARATION – RACCOMANDATIONS

Before the MRI, the patient has to meet the Physician in charge of the procedure to complete a medical history questionnaire (here below) necessary to rule out any possible contraindication to the procedure.

It is recommended:

- to leave all metal, ferromagnetic or magnetic objects and devices (cell phones, coins, watches, keys, earrings, brooches, jewellery, hair clips, magnetic stripe cards, credit cards, etc.) in the dressing room or in a locker,
- to remove dentures and hearing aids,
- to remove contact lenses or glasses,
- to undress and wear the disposable gown provided by the staff,
- to use the headphones or earplugs provided by the staff.

Patients should also avoid applying makeup and hair spray since these products can produce artefacts and lower image quality. **All through the procedure patients are required to lie very still while breathing regularly.** Patients should not discontinue their medications (e.g. medications for hypertension or diabetes).

PATIENT HISTORY QUESTIONNAIRE FOR MRI

Name _____ **Surname** _____ **place of birth** _____
date of birth _____ **address** _____
City, State _____ **telephone** _____
Weight KG.....
Have you had an MRI scan before?..... YES NO
· Do you suffer from claustrophobia?..... YES NO
· Have you ever worked (do you work) as a welder, lathe operator, body shop mechanic?
YES NO
· Have you ever had a car/hunting accident? YES NO
· Have you suffered explosion-related injuries? YES NO
Are you pregnant or possibly pregnant? YES NO
· Have you ever had an allergic reaction after receiving a contrast agent?..... YES NO
· Have you ever undergone surgery involving: (indicate YES NO)
Head Abdomen Neck.....
Extremities Chest.....Eyes.....
Oher.....in (year).....
· To your knowledge, do you have one or more medical devices or metal objects inside your body?
YES NO
· Have you any of the following:
Cardiac pacemaker or any other type of cardiac catheter?..... YES NO
Metal shrapnel or fragment?..... YES NO
Aneurysm clips (blood vessels), aorta, brain?..... YES NO
Heart valve prosthesis? YES NO
Stents?..... YES NO
Implanted defibrillator?..... YES NO
Spinal distractor? YES NO
Implanted insulin or medication pump?..... YES NO
Metal devices in the ears or hearing implants?..... YES NO
Neurostimulator, electrodes implanted in the brain or subdurally?..... YES NO
Other types of stimulators?..... YES NO
Intrauterine device(IUD)? YES NO
Spinal or ventricular shunt?..... YES NO
Dentures or partial plates?..... YES NO
Metal implants (from previous fractures, joint repair surgery), screws, nails, wire, etc.? YES NO
Other implants?..... YES NO
Where?.....
·Do you think you might have metal implants/devices/objects inside your body that
you ARE NOT AWARE of? YES NO
Do you have intraocular lens implants? YES NO
Do you have any body piercing jewellery? YES NO
Where?.....
Do you have any tattoos?..... YES NO
Where?.....
Are you wearing medication patches?..... YES NO

PREPARATION:

Before an MRI, the patient has to remove:

contact lenses, hearing aids, dentures, partial plates, hernia belts, hair clips and grips, eyeglasses, jewellery, watches, credit cards, magnetic strip cards, pocket knives, money clips, coins, keys, press fasteners, metal buttons, safety pins, clothes with zips, metal tweezers, metal stitches, metal nail files, scissors and any other metal object.

Patients are requested to remove their makeup before the procedure

The Physician in charge of the MRI procedure

Having taken note of the patient's answers and, where appropriate, after carrying out a medical examination and/or further diagnostic tests,

AUTHORIZES THE MRI PROCEDURE TO BE PERFORMED

Signature of the Physician in charge of the MRI procedure

Date

Signature of the interpreter, where appropriate

Date

INFORMED CONSENT of the patient to have the MRI procedure performed

THE PATIENT

Declares that he/she has been exhaustively informed about the risks and the contraindications relating to the exposure to the electromagnetic fields generated by the MR scanner. Therefore, being aware of the importance of the answers provided, the patient hereby gives his/her consent to have the procedure performed.

Signature of the patient (*)

Date

(*) If the patient is a minor
the signatures of both parents or of the legal guardian are required.

WITHDRAWAL OF CONSENT

I the undersigned _____ born in _____ on _____
hereby WITHDRAW my consent to have the above-indicated procedure performed.

Date _____

Signature of the patient/parents/legal guardian _____

Signature of the Physician in charge of the procedure _____