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## Magnetic resonance questionnaire

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- Sede ORBV Bellinzona    Tel. 091 811 86 54/55
- Sede OBV Mendrisio    Tel. 091 811 32 54
- Sede ODL Locarno    Tel. 091 811 46 28
- Sede ORL Lugano    Tel. 091 811 60 91

First Name: .....
Last name: .....
Date of birth: .....

Dear Patient,

You will undergo an MR exam.

You will be invited to take off your clothes and all removable objects: dentures, hearing aids, hairpins, glasses, contact lenses, jewellery, watches, wallets and coins, credit cards, keys, belts, clothing with metal parts, piercing, etc.

During the examination it is very important to stay immobile on the table in order to ensure the quality of the images taken. You will hear a rhythmic sound due to the MR scan operating.

A continuous contact between you and the radiographers will be assured during the entire procedure.

The exam's duration may vary from 20 to 60 minutes, depending on the area to be examined.

Sometimes an intravenous injection of a contrast fluid might be necessary.

We kindly ask you to complete the questionnaire on the back.

..... ..... ..... ..... .....
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*Questo modulo sostituisce IIMSI\_M-RX-017\_EN emesso il 26.03.2020 e revisionato il 01.01.2026*

**Please mark with a cross the corresponding answer:**

Have you already had an RM exam?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If so, in which hospital was the exam performed? .....		
Do you have any implant in your body?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Do you now have or have you ever had a pacemaker or defibrillator	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Artificial heart valves	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Cardiac stent, vascular stent or Bypass (year of surgery .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- An endoprosthesis of the aorta (thoracic or abdominal)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Do you now have or have you ever had electrical neuro-stimulator	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Cerebral clips (year of surgery .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Derivation valves (Shunt)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Insulin implanted pumps, micro-infusers and/or sensors for diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Orthopaedic prosthesis, surgical plates or clips	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Any other medical devices	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Any metallic items in your body or metal splinters of any type	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Dental prosthesis or appliances	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Hearing aids	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Implants in the inner ear (eg. a cochlear implant)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Contact lenses, eye prostheses or implants	<input type="checkbox"/> YES	<input type="checkbox"/> NO
- Piercing, tattoos, tattooed make-up, medicated plaster	<input type="checkbox"/> YES	<input type="checkbox"/> NO
History of prior surgery? Which? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Specifically, have you ever had heart surgery?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
History of kidney problems/disorders?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have diabetes or glaucoma?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have allergies? If so, which ones? .....	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you claustrophobic?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Your body weight: ..... Height? .....		
<b>For women:</b>		
Are you now or could you be pregnant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Date of last menstruation: .....		
Do you have a breast implant?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have an intrauterine device (eg. a contraceptive coil)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

**I confirm that I have read the above information and that my answers are correct to the best of my knowledge. I have had the opportunity to ask questions regarding the MR exam and I give my consent for the exam execution.**

Date: .....

Patient's signature (or signature of parent or guardian):

Data: .....

Nome e cognome o timbro del **medico che ha compilato il questionario\***:

Data: .....

Nome e cognome del **Tecnico di Radiologia**:

\* Solo nel caso in cui il paziente o il suo rappresentante legale/terapeutico non abbiano potuto compilare personalmente il questionario. Il medico ha compilato il questionario sulla base delle informazioni disponibili nella cartella clinica del paziente e delle informazioni fornite dal paziente (o rappresentante legale/terapeutico).