MAGNETIC RESONANCE IMAGING (MRI)

SAFETY QUESTIONNAIRE AND INFORMED CONSENT FOR CONTRAST ADMINISTRATION

Imp_crm_____ Edition ___ Date ___/___/_____

OBS No. _____ Date ____/____/_____ Weight _____ kg

IMPORTANT – Magnetic Resonance Imaging uses a very strong magnetic field. If you have a prosthesis/implant, do not enter the room unsupervised. Do not enter with metal objects (watch, earrings, bracelets, keys, etc.). Complete this form carefully; if in doubt, speak to the radiographer or the radiologist.

Have you had an MRI before? No ☐ Yes ☐ For what _____

Have you had surgery? No ☐ Yes ☐ For what _____

IMPLANTS AND DEVICES

ANSWER WITH A CROSS (X)	NO	YES
Do you have a pacemaker or an implantable cardioverter-defibrillator (ICD)?		
Do you have artificial heart valves?		
Do you have stents (vascular prostheses)?		
Do you have aneurysm clips or coils (cerebral, aortic or other)?		
Do you have a hearing aid and/or a cochlear implant?		
Do you have a dental implant, prosthesis, plate and/or brace?		
Do you have a shunt or valve (spinal or ventricular)?		
Do you have a neurostimulator or biostimulator?		
Do you have metal orthopaedic prostheses, plates, screws or pins?		
Do you have a medication infusion pump (internal or external, e.g. an insulin pump)?		
Do you have an implanted or subcutaneous glucose monitor?		
Do you have a weight-loss device (gastric band or balloon)?		
Do you have a penile prosthesis, an eye prosthesis, or a spring/wire in the eyelid?		
Do you wear a medicated adhesive patch on your skin (e.g. nicotine, nitroglycerin)?		
Do you have metal filings, lead shot and/or shrapnel in your body?		
Have you ever had an eye injury with a metal object/fragment, OR do/did you work with metals (welder, metalworker, lathe operator)?		
Do you have tattoos and/or piercings?		

If you have any implant/device, state the make/model and bring its implant card:

_____

HEALTH AND ALLERGIES

ANSWER WITH A CROSS (X)	NO	YES
Do you have claustrophobia?		
Do you have asthma or bronchitis?		
Do you have any allergies (medicines, food, other)?		
Do you have renal impairment?		
Do you undergo haemodialysis?		
Have you had examinations with a contrast injection before?		
Have you ever had an allergy to injected contrast?		

If you have allergies, to what?

_____

IF YOU ARE FEMALE

ANSWER WITH A CROSS (X)	NO	YES
Do you have a breast tissue expander?		
Do you have an intrauterine device (IUD)?		
Are you pregnant?		
Are you breastfeeding?		

If you are pregnant, how many weeks? _____

Before entering the examination room, remove all metal objects and put on the gown provided. External devices (e.g. an insulin pump, an external glucose sensor) must be removed or managed with the radiographer. The questionnaire is reviewed verbally by the radiographer; if there is any doubt, the decision to carry out the examination rests with the radiologist.

INFORMATION ABOUT THE CONTRAST AGENT

Sometimes, to help detect and/or characterise lesions, an injection of a contrast agent into a vein is needed, with your consent. The contrast agent used in MRI is a macrocyclic gadolinium-based agent – from the most stable, lowest-risk group.

It is generally well tolerated; mild, temporary effects may occur (headache, nausea, taste changes or reactions at the injection site). Less often, allergic reactions may appear (skin rashes, itching) and, rarely, severe anaphylactic reactions requiring immediate treatment (difficulty breathing, swelling of the face/throat, changes in blood pressure) – the team is prepared to treat these. In patients with pre-existing severe kidney disease, there is a rare risk of Nephrogenic Systemic Fibrosis (thickening of the skin, which can affect internal organs).

Kidney function: for the agent used (macrocyclic), a prior kidney-function blood test is not routinely required; if severe kidney disease is known, the decision is weighed individually by the doctor. Pregnancy: contrast is not given routinely – the absence of pregnancy will be confirmed before administration and it will only be used if essential. Breastfeeding: it may continue as normal after contrast.

CONSENT

MARK ONE OF THE OPTIONS WITH A CROSS (X):

☐ I AUTHORISE the intravenous administration of a contrast agent, if necessary.

☐ I DO NOT AUTHORISE the intravenous administration of a contrast agent.

I declare that the information given in this questionnaire is true and complete, that I have read and understood the information about the contrast agent, and that I confirm my choice, being able to withdraw this consent at any time, even after signing.

Signature or name of the patient or legal representative	Date
	____/____/_____
If the patient is unable to sign – identification (ID) number	**Relationship to patient**
Validated by (radiologist or radiographer)	**Date**
	____/____/_____

To be completed by the service – Contrast agent administered: _____ Dose: _____
Batch: _____

Data protection: the data collected are used solely to carry out the examination, produce its report and keep the clinical record, and are processed under the GDPR (Regulation (EU) 2016/679) and Portuguese Law No. 58/2019. You may exercise your rights of access, rectification and the other rights provided by law with CRMA (Data Protection Officer).