

Please answer for us the following questions, for your own safety and for the best examination quality that can be achieved.

Please hand in any findings, CD-ROMS and X-ray pictures at the registration desk!

Surname: _____ First name: _____ Born: _____

Telephone: _____ Body weight: _____ Body height: _____

1. General questions

Do you wear a cardiac pacemaker defibrillator event recorder artificial heart valve
 shunt hearing aid metal components magnetic implants clips cochlear implant
 neurostimulator stents metal splinters dental prosthesis attached with a magnet
 diabetes sensor insulin pump anything else

If so, since when? _____

Do you have piercings and/or tattoos? no

Do you suffer from **claustrophobia** (anxiety in enclosed spaces)? yes no

Have you already had an operation in the region of the body to be examined? yes no

Are you aware that you have any **allergies**? yes no

If so, what allergies? _____

Were there any **issues with contrast agents being given** at previous MR examinations? yes no

Do you suffer from a **dialysis-dependent renal insufficiency**? yes no

Are or were you aware of having any **tumour diseases**? yes no

Do you have/Have you had an **infectious disease/chronic health condition**,
e.g. HIV, hepatitis tuberculosis or rheumatism? yes no

If so, which one(s)? _____

For women: could you be **pregnant**? yes no

2. Agreement on passing on images and findings, and on any related requests, pursuant to Sec. 73(1)(b) German Social Code (SGB) V:

Passing on

I hereby grant permission for my data on findings and images to be passed on to the physicians transferring me. yes no

I hereby grant permission for my data on findings and images to be passed on to the physicians continuing to treat me. yes no

My general practitioner (please enter details): _____

In addition, within the scope of the random quality checks conducted by the Association of Statutory Health Insurance Physicians, your images, diagnostic data and any treatment documents may be required. No separate declaration of consent is to be obtained from you for that purpose.

Requests

I am in agreement with the DiaCura Radiology Practice obtaining information and image data from the physicians treating me in the context of medical diagnostics. yes no

I may revoke this consent in writing or by telephone, at the number +49 9561/231000, at any time.

You can find further information on data privacy pursuant to Art. 13 EU GDPR on our website at www.diacura.de

Only for accidents at work/school/en route to work or school (via the professional association):

DiaCura Radiologie is obliged to provide information to accident insurers (pursuant to Sec.100 [German Social Code (SGB) X], Sec. 201 [SGB VII] in conjunction with Sec.46 of the Agreement between Physicians and Accident Insurers). Accident insurers may request data from DiaCura (pursuant to Secs. 199, 201 SGB VII, Sec. 67a SGB X). Based on the statutory provisions, you may require your professional association to provide information on the data transmitted.

Date

Signature of Patient

Date

Legal Guardian in the case of patients who are minors or the Healthcare Professional on duty in the case of patients on the ward. (Full details as per the patient chart)

Please just read!

Consent to Examination and the administering of medication

(We will fill in the following details together with you)

IMPORTANT NOTE:

Prior to commencement of the examination, it is necessary to remove any loose metallic items. These also include hair slides, removable dentures, jewellery, spectacles, keys, clocks, hearing aids, mobile phones and parking cards, bank cards or credit cards.

3. Patient briefing

Scheduled examination: Magnetic resonance imaging

Scheduled or any necessary contrast agents/the administering of medication.

Administration of a contrast agent (CA), and an anti-allergic agent, should any CA reactions occur

Administration of a sedative to counteract my claustrophobia (Midazolam)

I am aware that, if Midazolam or any *anti-allergic* agent is administered,
I may not actively take part in traffic within the next 24 hours.

yes no

Administration of an intestinal relaxant (Buscopan) in the case of certain abdominal examinations.

I have read and understand the information sheet on the scheduled examination.

I am informed about any contra-indications and side effects of the examination,
as well as the scheduled administration of medication and hereby dispense with
any additional verbal clarification by the physician.

yes no

4. Consent

I consent to the scheduled examination being carried out.

yes no

Should the administration of a contrast agent/medication be necessary,
I am in agreement with it.

yes no

In the case of minors: As legal guardian, I consent to the administration of medication and
the examination of my child.

yes no

Date

Signature of Patient

Date

Legal Guardian in the case of patients who are minors

Patient does not have the capacity to understand any explanation / examination medically necessarily

yes no

Date

Signature of Patient

Date

Legal Guardian in the case of patients who are minors

I wish to receive a print-out of this data entry form.

yes no

Signature of Employee: _____

Physician's Assistant Medical Technical Radiology Assistant Physician