# CT

DiaCura Radiologie

**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 suffer from **diabetes?** yes ☐ no ☐

What medications do you take for it? ______

Do you suffer from **renal impairment** and/or do you undergo **dialysis?** yes ☐ no ☐

Do you have **thyroid dysfunction?** yes ☐ no ☐

What medication do you take? ______

Are you aware of having any **allergies**? yes ☐ no ☐

If so, what allergies? ______

Has a computer tomography been carried out previously? yes ☐ no ☐

When, where and of what body region? ______

Did any **problems arise** following previous **X-ray contrast agent examinations?** yes ☐ no ☐

If so, what problems? ______

Have you already previously had an operation **in the area examined?** yes ☐ no ☐

If so, what kind of operation? ______

**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 ☐

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 Radiology 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)

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# Please just read!

DiaCura
Radiologie

## Consent to Examination and the administering of medication

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

### 3. Patient briefing

☐ **Scheduled examination: Computer tomography**

☐ **Scheduled administration of an intravenous contrast agent, an anti-allergic medication if required**

I am aware that if any *anti-allergic agent* is administered, I may not actively take part in traffic within the next 12 hours. yes ☐ no ☐

☐ 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 administration of a contrast agent (if stipulated), and hereby waive an additional verbal explanation by the physician. yes ☐ no ☐

### 4. Consent

**I hereby consent to the scheduled examination being carried out.** yes ☐ no ☐

**I am in agreement with the scheduled administration of a contrast agent/medication.** 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 ____________

**I wish to receive a print-out of this data entry form.** yes ☐ no ☐

Signature of Employee: ______________________________

Medical Technical Radiology Assistant Physician