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ID No. 00098892

Informed Consent of the patient (patient's legal representative) to Magnetic Resonance

Patient – Name and surname:	Birth number: (insurance number):
Date of birth: (if no birth certificate number exists)	Insurance provider code:
Height:	Weight:
Patient's permanent address: (or other address)	
Name of legal representative (guardian):	Birth Certificate Number:

Name of the procedure

Magnetic Resonance

Purpose of the procedure

This visualization method takes advantage of the changes in magnetic fields in the body tissues. Human body tissues are visualized by means of this method especially in the case of neurological diseases, locomotor system diseases, and diseases of the chest, abdomen and pelvic organs.

Nature of the procedure

The following is necessary before the examination!

- Do not eat 2 hours before the examination, intake of clear liquids is permitted (100 ml per hour).
- For the sake of hygiene and safety, put on the prepared coat before entry into the examination area.

Procedure:

The examination is painless and takes 20 – 60 minutes. During the examination you will be placed in a cylindrical space. You must lie still throughout the examination. The examination space is lit and air-conditioned. When the apparatus is working, you will only notice different kinds of distant noise. In justified cases, you may be administered a contrast substance intravenously over the course of the examination.

Contraindications:

Magnetic resonance is one of the safest examination methods. However, it presents certain limitations ensuing from its very essence.
It is impossible to examine patients with an implanted pacemaker, cardiac defibrillator, cochlear prosthesis or other electronically controlled instruments (insulin pump, etc.).
Patients with a metal object in their eye may not be examined either.
Patients with implanted metal clips, metal splints, heart valve prostheses, etc. also present certain limitations.
Special attention is paid to individuals in a post-accident condition whose body might contain metal material as a result of the accident.
A significant limiting fact complicating the possibility of conducting the examination is anxiety from constrained and enclosed spaces.
During pregnancy the examination is conducted only in exceptional cases.
You will be repeatedly questioned about all these issues prior to the commencement of the examination and, should any doubts arise, we will make a joint assessment of all the aspects involved.

<u>After the procedure:</u>

- There are no limitations.
- Following the examination, the information obtained will be processed; the results will be sent to the doctor who ordered the examination.

Should you have any problems you must inform the attending physician immediately!!!

Expected benefits of the procedure

Visualization and evaluation of pathological or shape changes in the region under examination, possibly leading to further treatment procedures.

Alternative procedures

Examination using computed tomography or ultrasound (where appropriate and possible).

Possible risks of the selected procedure

Possible complications:

If all of the above-mentioned contraindications are observed, complications resulting from the procedure are at a minimum.

Their number has considerably decreased as a result of the development of new technologies leading to an improvement in the apparatus and contrast substances.

Most frequent complications include:

- Reaction to being in an enclosed space
- Allergic reaction to the contrast substance – these reactions are rare, mostly of a mild nature (such as nausea, urticaria, dyspnoea, and oedema); it is absolutely exceptional that a severe reaction occurs or that a patient's life is jeopardized.

Consequences of the procedure

No consequences unless there is a severe reaction to the contrast substance.

In order to reduce the risk of complications and, above all, that of an allergic reaction to a minimum, we kindly ask you to answer the following questions:

note Circle your answer:

1. Do you have an implanted pacemaker, defibrillator, cochlear prosthesis or other electronically controlled instrument?	YES	NO
2. Do you have a foreign body in your eye?	YES	NO
3. Do you have any metal material in your body?	YES	NO
4. Do you suffer from anxiety in enclosed spaces?	YES	NO
5. Did you have an allergic reaction during the previous intravenous administration of a contrast substance?	YES	NO
6. Do you suffer from serious kidney disease?	YES	NO
7. Are you pregnant?	YES	NO

If anything is not clear to you and you want to ask questions, we are prepared to answer them.

Consent:

I have been informed in a comprehensible manner of alternative procedures performed at University Hospital Olomouc, from which I may choose.	YES	NO
I have been informed of possible limitations in my normal life and work ability following the procedure concerned and, in the case of a possible or expected change in my medical condition, also of the changes in my medical condition.	YES	NO
I have been informed of the treatment regime and appropriate preventive measures and of the performance of control medical procedures.	YES	NO
I understand all these explanations and instructions communicated and provided by the healthcare worker, and I have had the opportunity to ask additional questions which have been answered by the healthcare worker.	YES	NO

Following the above-mentioned familiarization I hereby declare:		
- to consent to the treatment proposed and to the performance of the procedure; in the case of the occurrence of unexpected complications requiring urgent performance of further procedures necessary to save my life or health, I also consent to the performance of any such necessary and urgent procedures.	YES	NO
- that I have not concealed from the doctor(s) any information about a medical condition that I am aware of and which could negatively affect my treatment or endanger my surroundings, especially by spreading a contagious disease.	YES	NO
- that, if needed, I consent to the sampling of biological material (blood, urine, etc.) for necessary examinations, especially in order to exclude a contagious disease.	YES	NO

I agree that students and trainees access my medical records only to the necessary extent and on the basis of a mandate provided by a medical professional.	YES	NO
- that I agree to the use of the results of my examinations as part of routine diagnostic and treatment procedures for scientific and educational purposes on the condition that these data will be presented and published only in anonymous form.	YES	NO
I agree with the presence of students and trainees during the provision of health care services.	YES	NO

I request that the following individual(s) is (are) informed of my medical condition:			YES	NO
First name and surname:	Address:	Tel:		
I request that the above-mentioned individual(s) has (have) the right to:				
a) Inspect my medical records			YES	NO
b) Make abstracts, duplicates or copies of my medical records.			YES	NO

Date	Hour	**Signature of the patient or** (patient's legal representative)

Name, surname of the authorized healthcare worker who instructed the patient	**Signature of the authorized healthcare worker** who instructed the patient

Name and surname of the doctor performing the procedure	**Signature of the doctor** performing the procedure	Date	Hour

If the patient cannot sign, indicate the reasons for this limitation:			
The way the patient showed his/her will:			
Name and surname of the medical professional / witness	**Signature of the medical professional / witness**	**Date**	**Time**