

Before the examination of **MRI**, please answer carefully to the following questions :

Surname : Name : Date of birth : /..... /..... Weight :Kg Height :m



Have you got a **pacemaker, implantable cardiac defibrillator, implantable Holter or neurostimulator?**.....YES NO

Have you ever had heart surgery (**heart valve prosthesis, stent, caval filter, coronary bypass**)?..... YES NO

If so: - year of the implant: - type:



Have you ever had **brain surgery, eye surgery?**..... YES NO

If so, with implant (**neurosurgical clips, cerebral ventricular shunt, ear implants**)?.....YES NO



Have you got **hearing aid?** (Must remove prior to MRI)..... YES NO



Have you got **dentures?**..... YES NO



Are you **diabetic?**..... YES NO

If so,

Do you carry on **insulin pump?**..... YES NO



Do you have tatoos and/or piercing ? ?..... YES NO



Have you got **surgical prosthesis** (hip, knee, nail).....YES NO

Do you work with metal (**metallic splinters in eyes**)?..... YES NO

Do you suffer from **kidney dysfunction** YES NO

Do you suffer from allergies (drugs, food, **asthma, iodine**)?..... YES NO

Have you got a blood pressure treatment (**Beta-blocker**)?..... YES NO

Have you got a **transdermal patch?**..... YES NO

Are you **claustrophobic or anxious?**..... YES NO



Are you pregnant or think you could be pregnant? YES NO

Are you breastfeeding?..... YES NO

Information that seems **significant** to be communicated and **serious illness** (**Hepatitis C, HIV, cancer...**) or **previous surgical intervention**:

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Due to the strong magnetic field and waves from the MRI, **some items are not allowed in the examination room**, a safe is at your disposal:

- **Hearing aid, dentures, jewels, piercings, Credit card, magnetic card, coins, Mobile phone, watch, keys, lighter**

In the past 48 hours have you had any of the following symptoms :

- **Cough?**.....YES · NO ·
- **Fever (chills,sweat)?**.....YES · NO ·
- **Have you had Covid cases around you ?**..... YES · NO ·

I declare that I am aware of the different procedures and risks linked to the examination and give my consent for it to be carried out. I agree that my personal data will be archived and transmitted to the medical profession. (Specialist doctors, RCP, general practitioner, etc.)

Done in Mougins, on

Signature:

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