Taipei Veterans General Hospital
Instruction and Consent form for Magnetic Resonance Imaging Examination

Ward/Bed#: _____/_____Dpt./Dv._____
Medical Record No.: _____—□
Name of Patient: _____Sex: □M □F
Patient's Date of Birth:____Year____Month____Day

Instruction form for Magnetic Resonance Imaging Examination

I. The purpose of suggested exam:
To better understand the current conditions of your internal organs.

II. Method of examining:
Image examination is performed through changes in a magnetic field. The administration of intravenous contrast media is used to improve the diagnosis and evaluation of the disease when necessary.

III. Risks of the examination:
MRI scan is a special examination conducted in a strong magnetic field. In order to protect the patient's safety and improve diagnostic accuracy, please confirm the following questions carefully and notify the staff before taking this examination in order to avoid any danger:

- Have cardiac pacemaker / artificial heart valve / IVC filtered Swan-Ganz Catheter / defibrillator
- Have you undergone cranial aneurysm surgery with clamp or stents
- Have you been injured previously and may have metal dust leftovers in the eyes
- Have you had a Cochlear / ear implant / hearing aid
- Do you have any electrode / stimulator / neuro stimulator / medication implant
- Do you have any implant held in place by a magnet (e.g. dental)
- Do you use insulin or infusion pump
- Do you have any body piercing(s) / tattoos / permanent makeup (e.g. eyeliner, lips)
- Have you undergone an operation using wire stitching / steel plate / nail / pin / artificial joint / metal denture or filling / plate / surgical staple (If one of the above mentioned situation is met, MRI is not suitable).
- Do you use the transdermal delivery system (Nitro) / tissue expanders (plastic surgery)
- Do you wear colored contact lenses
- Are you pregnant (MRI is not suggested in the first trimester unless there is no substitute examination)
- Are you allergic to any medication or food? If yes, please specify in the declaration form at the last page.

IV. Possible complications of the examination and procedures for alleviation:
MRI often uses intravenous gadolinium-based contrast medium to check if there is any pathological change. While this contrast media is much safer than the contrast media used in CT and IVU, some patients may still experience the following adverse effects:

1. Local vein or muscle pain (incidence: <0.5%), can be relieved by cold compression;
2. Allergic reactions: nausea, vomiting, stomach ache, night sweats, general discomforts, fever, general itches from urticaria or breathing difficulties (incidence <0.5%), can be relieved by antihistamine or steroid;
3. There have been very few cases of sudden death from contrast allergy (incidence: <0.01%); there is, to the present, no reliable test can predict this kind of severe allergy;

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4. Those with impaired renal function/renal failures are at risk of nephrogenic systemic fibrosis (incidence: 0.19~4%), which is characterized by deposition of contrast medium in soft tissue with subsequent fibrosis and myofascial discomfort. The incidence of nephrogenic systemic fibrosis is even much rare with the highest-safety MRI contrast media regularly used in our hospital and the liver specific agent (Primovist@) that belongs to the class of medium-safety. Patients under hemodialysis is advised to take the contrasted examination before the hemodialysis.

V. Possible transient or permanent symptoms

So far, there have been no documented reports of significant temporary or permanent symptoms caused by the examination itself.

VI. Alternative methods

1. MRI may be performed without the administration of the contrast media. However, in some cases, the accuracy of this type of examination is less and this may affect the diagnosis.
2. Please discuss with your clinical physician regarding to other imaging examinations to replace MRI.

VII. Things you should know before, during and after examinations

1. Please call the following number to update your appointment if you cannot make it on your scheduled time, otherwise it would be regarded as cancelled (02-28712121 ext. 3038, MRI counter).
2. When the patient is a minor (under 18 years old) or unable to give consent for other reasons, the signature should be provided by the legal representative, spouse, relative or other relevant person.
3. Do not bring valuable items with you.
4. Please do not wear clothes with metallic parts or decoration.
5. When NPO is required for upper abdomen examination, please don't take DM medications or insulin..
6. Due to different individual conditions, the waiting time might be extended, please be patient.
7. If you have claustrophobia (e.g. can't tolerate staying in a small space such as elevator), please notify your doctors in charge or the radiology technician beforehand.
8. You will hear repeated knocking sounds during the examination, which is caused by the normal operation of the machine. We will provide ear plugs to help to reduce the noise.
9. After the examination, there are no special precautions to take, and everything can resume as normal.
10. During the examination: Claustrophobia: Patients with claustrophobia (the majority of patients are unaware if they have this type of fear) will experience severe discomfort in a small examination room. Because magnetic resonance imaging (MRI) scans are performed in a relatively confined space, if you cannot tolerate riding in an elevator or staying in a windowless room for a long time, please inform your doctor or radiologist in advance.

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VIII. Health insurance benefits:

1. The examination itself is paid for by the National Health Insurance. If this changes in the future, it will be processed according to the new regulations.
2. Self-paying patients please pay according to the hospital regulations. Difference price ranges is according to the usage of the contrast media.

(Please contact the Radiology Department if there are further queries: 02-28757594)

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I. Scheduled Examination (If the medical terms are not clear, please note with the brief explanations)

1. Ailment: _____
2. Suggested examination (treatment/procedure): Magnetic Resonance Imaging
3. Reason for suggested exam: _____

II. Physician's declaration

1. I have explained to the patient about this examination to his/her understanding, with the best of my ability. The following have been emphasized:

- □ Reasons and purposes for conducting the examination.
- ☐ Possible consequences of not undergoing the examination.
- ☐ Examination methods.
- ☐ Risks and probabilities associated with the examination.
- ☐ Temporary or permanent symptoms that may occur after the examination.
- ☐ If there are any other relevant information about the examination, I have provided it to the patient
- ☐ Other possible alternative examination methods.
- ☐ Complications that may arise from the examination and possible treatment options.

2. I have given the patient sufficient time to ask the following questions concerning this examination, and have given the following answers:

(1)_____
(2)_____

Doctor's signature:_____Date: Day____Month____Year____Time: Hour____Minute____

III. Patient's declaration

1. The physician has explained to me, and I fully understand the relevant information on the reason, procedure, and risk etc. for this examination.
2. The physician has explained to me, and I understand the possible outcomes of undergoing the examination, the risks of not undergoing it, and other alternative methods of examination.
3. I have also responded to the following questions (Yes-V, No-X):

- ☐ Please fill in: Weight____kg; Height____cm
- ☐ Are you pregnant? Number of weeks pregnant:_____weeks
- ☐ Do you have a pacemaker?
- ☐ Do you have any artificial heart valves, implanted blood vessels, etc.? If yes, please fill in the

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☐ Have you undergone surgery for cerebral aneurysm and currently have remaining aneurysm clips?

☐ Do you have any artificial electronic ear/internal electrode stimulator/implanted drug injector/skin tissue expander/magnetically fixed implant, etc.?

☐ Do you have an adjustable brain or spinal fluid drainage tube device?

☐ Have you experienced trauma and may have residual metal fragments in your eye socket?

☐ Have you had any of the following surgeries: using wire sutures or steel plates/nails for fixation, artificial joint implantation, metal dentures or crowns, or currently wearing metal braces?

☐ Do you have any tattoos/permanent makeup (eyebrows/eyeliners)/hair dye with metal content?

☐ Have you ever had a drug or food allergy? If yes, please fill in the name of the drug or food:

_____

☐ Before undergoing the examination, please be sure to remove: removable dentures, hearing aids, any items in the front and back pockets of clothing, watches, any bracelets, hair clips, belts with metal buckles, shoes with metal buckles or materials, mobile phones/tablets, necklaces, heat pads, patches, colored contact lenses, magnetic false eyelashes, etc.

4. I understand that if an organ or tissue needs to be removed during the examination, the hospital may keep them for a period of time for examination purposes and will handle them carefully and in compliance with the law.
5. I understand that this examination might be the most appropriate option currently, but it does not guarantee the improvement of the disease course or outcome.
6. I am able to ask the doctor questions and express concerns about my condition, the process of the examination, and the method of the examination. I have received explanations from the doctor.

Based on the above statement, I □ agree □ disagree to undergo this examination

Name of person completing the form: _____

Relationship to patient: _____

Address:_____Telephone:_____

Date: Day_____Month_____Year_____Time: Hour_____Minute_____

Witness Name: _____

Witness Signature: _____

Address:_____Telephone:_____

Date: Day_____Month_____Year_____Time: Hour_____Minute_____

Note:

1. When the patient is a minor (under 18 years old) or unable to give consent for other reasons, the signature can be provided by the legal representative, spouse, relative or other relevant person.
2. If the person completing the form is not the patient him/herself, please fill in your relationship with the patient.
3. If there is no witness present, leave it blank.