# 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

## 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 often uses intravenous gadolinium-based contrast media to confirm if there is any pathological change. While this contrast media is much safer than the contrast media used in regular X-rays, some patients may still face the possibilities of the following adverse effects:

1. It may cause local veins or muscle pain (incident rate: <1%);
2. Allergic reactions to medications are: nausea, vomiting, stomach ache, night sweats, general discomforts, fever, general itches from urticaria or breathing difficulties (incident rate: <1%);
3. There have been very few cases of sudden death from medication allergy (incident rate: <1%);
4. Those will impair renal function/renal failures are at risk (3-5%) of nephrogenic systemic fibrosis, which is characterized by deposition of contrast over soft tissue and subsequently induce fibrosis and myofacial discomfort.

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
☐ Are you allergic to any medication or food? If yes, please specify:_____

## IV. Possible complications of the examination and procedures for alleviation:

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1. It may cause local veins or muscle pain (incident rate: <1%);
2. Allergic reactions to medications are: nausea, vomiting, stomach ache, night sweats, general discomforts, fever, general itches from urticaria or breathing difficulties (incident rate: <1%);
3. There have been very few cases of sudden death from medication allergy (incident rate: <1%);
4. Those will impair renal function/renal failures are at risk (3-5%) of nephrogenic systemic fibrosis, which is characterized by deposition of contrast over soft tissue and subsequently induce fibrosis and myofacial discomfort.

## V Possible transient or permanent symptoms:

There is no evident report concerning significant transient or permanent symptoms

## 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. Radiologist will determine if contrast is needed based on your condition.
2. Due to different individual conditions, the waiting time might be extended, please be patient.
3. Do not bring your valuable items with you.
4. Please do not wear clothes with metallic bottoms/zippers.
5. Medications for heart disease and hypertension may be continued, except Diabetes Mellitus.
6. 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, Radiology Department).

**During the examination:** There will be a repeating sound of knocking noises throughout the examination, this is normal. If this noise makes you uncomfortable, please inform the staff.

**Claustrophobia:** Patients with claustrophobia (not many people know they have this), please inform the staff.

## V. 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: 02-2875759)

# 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

## I. Scheduled Examination (If the medical terms are not clear, please add 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:

- ☐ The reasons for the examination, its method and scope, risk and success rate.
- ☐ Possible complications of the examination and the procedures for alleviation thereof.
- ☐ Alternative methods.
- ☐ Nephrogenic Systemic fibrosis (NSF) will occur if patients with poor kidney function is injected with 3~5% Gadolinium-containing contrast agents.

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 fully understand the necessity, procedure, and risk for this examination.

I have also responded to the following questions (Yes-V, No-X):

- ☐ 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 / ontological / 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

☐ 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

☐ Do you use the transdermal delivery system (Nitro) / tissue expanders (plastic surgery)

☐ Do you wear colored contact lenses

☐ Are you pregnant

☐ Are you allergic to any medication or food? If yes, please specify:_____

☐ Please remove: all contents of pockets, including back pockets, wrist watch, any bracelets, hair pins and clips, belt with metal (e.g. buckle), shoes that contain any metal (e.g. steel-tipped), pager and phones, necklaces and chains.

3. The physician has explained to me, and I fully understand the possible complications and risks if the examination was not performed.

4. I understand that this examination may be the most appropriate option right now. Based on the above declaration, I agree to undergo this examination and **I ☐agree ☐do not agree to receive contrast medium**

Name of person completing the form: _____

Relationship to patient: _____

Address: _____ Telephone: _____

Date: Day_____Month_____Year_____ Time: Hour_____Minute_____

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Witness Name: _____

Witness Signature: _____

Address: _____ Telephone: _____

Date: Day_____Month_____Year_____ Time: Hour_____Minute_____

**Note:**

1. If the person completing the form is not the patient him/herself, please fill in your relationship with the patient.

2. If there is no witness present, leave it blank.