INFORMED CONSENT FOR AN MRI EXAMINATION

Patient name and surname:_____Date of birth: _____

Personal ID No: _____/_____Health insurance provider code: _____

Address: _____Weight: _____kg Height: _____cm

Legal representative: _____Relationship (e.g. mother): _____

Date of birth: _____Address (if different to that of the patient): _____

Dear Madam, Dear Sir,

Your attending physician has recommended that you undergo magnetic resonance imaging (MRI). This is one of the most advanced diagnostic methods currently available, capable of examining a wide range of human organs, including the brain, joints and abdominal organs.

The procedure does not operate on the principle of X-ray radiation, and the electromagnetic energy used in MRI has not been shown to produce harmful biological effects. Even so, we avoid performing MRI examinations on pregnant women in the first three months of pregnancy.

In some cases, the nature of the MRI examination requires the administration of a contrast agent into a vein. MRI contrast agents are, in most cases, specialised compounds based on the rare metal gadolinium. They are administered in small amounts (approx. 10-20 ml), and the risk of an allergic reaction is statistically significantly lower than with iodine-based contrast agents.

Reason for the procedure

Examination of a large proportion of the body's organs.

How the procedure is carried out

During the examination itself, you will lie on the scanning table within a strong magnetic field. The alternating fields generate considerable noise, which is an inherent part of the examination and not a sign of a malfunction. Around the part of the body being examined, a coil will be positioned to receive signals from the tissue. The examination usually lasts 20 to 60 minutes, and you will be asked to remain still throughout it. For certain examinations, particularly of the abdominal organs, you may be asked to hold your breath for a short period. No special preparation is required for the examination itself. Before an abdominal-organ examination, please refrain from eating and drinking for four hours.

Risks and possible complications of the procedure

MRI scans are usually very safe, but there are a few specific risks. As the scanner uses a strong magnetic field, people with certain electronic or metal implants, or other magnetisable foreign objects, cannot be scanned. People with a pacemaker or implanted defibrillator (ICD) cannot have an MRI scan because it could interfere with the device and cause dangerous, even life-threatening heart rhythm problems. If you have a metal clip from surgery for a brain aneurysm, an MRI scan is possible only if trained MRI staff confirm that it is safe; otherwise, the clip could shift and cause serious bleeding. For some MRI scans, a contrast agent is given through injection into a vein. Side effects are rare, but you may experience a headache, nausea, brief dizziness, or soreness where the needle was placed. Rare reactions can include allergies, rashes, vomiting, breathing problems, heart rhythm issues, swelling or kidney problems. Some tattoo and permanent make-up inks may contain iron compounds that can cause a burning feeling in the magnetic field and, in rare cases, skin reactions or even burns. To reduce the chance of these problems, please read the questions below carefully and answer them as accurately as you can.

If you have a pacemaker or any metal object in or near the eye socket or brain, the scan could be dangerous for you, so we cannot perform it.

Supplementary information for magnetic resonance imaging (MRI):

Circle a single answer each time. If you answer YES, provide details.

The following circumstances could make an MRI scan unsafe or unsuitable for you:

Have you ever had an MRI scan before?	YES	NO	
Have you ever had any problems during an MRI scan?	YES	NO	
Have you ever undergone surgery?	YES	NO	
Do you have kidney disease?	YES	NO	
Do you have asthma?	YES	NO	
Do you get claustrophobic (fear of small or enclosed spaces)?	YES	NO	
Are you allergic to anything?	YES	NO	
Have you ever been given an MRI contrast agent?	YES	NO	
Have you ever had an allergic reaction after receiving an MRI contrast agent?	YES	NO	
Are you pregnant, or do you suspect you might be?	YES	NO	
Pacemaker	YES	NO	
Electronic wires or electrodes (including leftover ones after a pacemaker was removed)	YES	NO	
Implanted heart defibrillator	YES	NO	
Surgical clips or metal pins	YES	NO	
Metal object in the body (bullet, fragment, splinter, etc.)	YES	NO	
Joint replacements (hip, knee, etc.)	YES	NO	
Back surgery with metal implants or stabilisers	YES	NO	
Hearing aid	YES	NO	
Cochlear implant or other ear implant	YES	NO	
Implanted pumps (insulin or pain-control pumps)	YES	NO	
Vascular clips	YES	NO	
Stents (heart or other blood vessels), **vascular filter**	YES	NO	
Shunt (please say which kind)	YES	NO	
Intrauterine device or pessary	YES	NO	
Dental prostheses, implants, bridges, posts or braces	YES	NO	
Artificial limbs	YES	NO	
Artificial heart valves	YES	NO	
Neurostimulator	YES	NO	
Tattoos	YES	NO	
Other implants	YES	NO	

Patient or legal guardian declaration

I have been informed of the purpose, nature, expected benefits, consequences and possible risks of the proposed health services (medical procedure).

I have been informed of the alternatives (other options) to the proposed health services (medical procedure), including their advantages and risks, and I have had the opportunity to choose one of these alternatives (where such a choice exists and where the procedure is not subject to special legal regulations).

I have been informed of the possible limitations in my usual daily activities and of any potential work incapacity after the provision of the health services (medical procedure), and any expected changes in my health condition and medical fitness.

I have been informed about the treatment plan, recommended preventive steps, and any follow-up checks that may be needed.

I have been informed of my right to freely decide on the course of the healthcare services provided to me, unless such a right is excluded by other legal regulations.
I have not withheld any information known to me about my health condition that could adversely affect treatment or endanger those around me, particularly through the spread of an infectious disease.
I agree to the necessary use of restraining measures whose purpose is to avert an immediate threat to life, health or safety in connection with the provision of the health services (medical procedure).
I declare that I have been informed of the possibility of withdrawing this informed consent, and I acknowledge that any withdrawal will not be effective once the medical procedure has begun, if interrupting it could cause serious harm to health or endanger life.
In the event of unexpected complications requiring the urgent performance of additional procedures necessary to save life or health, I agree that all further necessary and urgent procedures required to protect life or health may be carried out.
I declare that I have been able to ask additional questions, that these have been duly answered, and that I fully understand the information and instructions provided. I agree to the provision of the proposed health services (medical procedure).

Assessment of the capacity of a minor patient or patient with limited legal competence to give consent

(to be filled in by the physician providing the information and instructions)

☐ The patient is fully able to understand and freely give consent to the proposed health services.
☐ The patient is not fully able to understand and freely give consent to the proposed health services.

Physician (healthcare professional) providing the information and instructions:

Name label (in block lettering/stamp): _____ Signature: _____

In Hradec Králové, dated _____ at _____ (time)

Patient or legal representative signature: _____

The patient's current health condition does not allow them to sign this consent, because:

Alternative way of expressing consent:

☐ By a nod of the head
☐ With a gesture: _____
☐ With the eyes
☐ Other: _____

Witness:
Name and surname, signature: _____
If the witness is not an EUC employee, include their address and date of birth.

Fill in if the patient (or legal representative) refused to sign the consent.
The patient (or their legal representative) refused to sign the consent.
Physician (healthcare professional) providing the information and instructions: _____

Date and patient signature: _____

Contraindications to an MRI examination have been identified: ☐ YES ☐ NO

Physician signature: _____ **Radiology assistant signature:** _____

Consent of the minor patient's representative for treatment/examination

Details of the minor patient:

Name and surname: _____ Date of birth: _____

Permanent address: _____

Details of the legal representative:

Name and surname: _____ Date of birth: _____

Contact (telephone, e-mail): _____

As the legal representative of the above minor patient, I hereby grant consent, in accordance with Section 35(2)(a) of Act No 372/2011, on health services, for the healthcare provider listed below to provide the minor patient with the specified health service:

_____

Please specify the field/type/scope of the healthcare service for which you are giving consent, e.g. blood sampling, allergy examination, surgical treatment, repeated check-ups with a physician (name of physician, etc.)

Granting this consent does not affect the legal representative's right to information about the minor patient's health condition, information about the healthcare provided, or any other rights granted by law. This consent may be withdrawn by the legal representative at any time.

Details of the healthcare provider:

Name: EUC Klinika Hradec Králové s.r.o.

Address of the healthcare facility: Bratří Štefanů 895/1, 500 03 Hradec Králové, company ID No: 48169820

In Hradec Králové, dated: _____ **Legal representative signature:** _____

I confirm that I have received this consent and added it to the minor patient's medical file.

In Hradec Králové, dated: _____ **Physician signature:** _____