



PATIENT'S CONSENT FOR MAGNETIC RESONANCE IMAGING (MRI)

Study number _____

Date of examination _____

Healthcare Provider stamp _____

Payer of benefits _____

Patient's forename and surname: _____

Date of birth: _____

PESEL(Personal ID number): _____

E-mail Address: _____

Address: _____ **Phone number:** _____

Zip code: _____ **City:** _____

Patient weight: _____ **Patient's Height:** _____

If patient is a minor, full name of statutory representative.

1. Area of the body subject to scanning.

2. Diagnosis, main symptoms (what is the test supposed to explain?)

OBJECTS IN THE PATIENT'S POSSESSION DURING THE EXAMINATION MAY POSE A RISK TO THEIR HEALTH OR LIFE.

During the examination, the patient is exposed to a very strong electromagnetic field, which means that the patient cannot have any metal objects or objects that are sensitive to this field, such as hearing aids, watches, electronic devices, magnetic cards, mobile phones.

THE WORKSHOP IS NOT RESPONSIBLE FOR ANY DAMAGE TO THESE ITEMS.

Due to the noise associated with the examination, we recommend using noise-cancelling earplugs. The test requires staying still and in a confined space for several minutes. Makeup may prevent or significantly reduce the quality of the head examination. For the MRI examination, please wear clothes without metal accessories (zippers, snaps, etc.) and do not wear jewelry. I kindly ask you to complete the questionnaire below. All medical information is subject to medical confidentiality and will not be used for non-medical purposes.

Please do not bring valuables into the facility. The staff is not responsible for lost items.

	YES	NO
1. For women: Are you pregnant or do you think you may be pregnant?		
2. Do you suffer from claustrophobia?		
3. Do you have any of the following conditions? (If yes, please tick as appropriate)		
<ul style="list-style-type: none"> • electronic, mechanical or magnetic implants (pacemaker/internal electrodes)_____ 		
<ul style="list-style-type: none"> • internal or external hearing aid, 		
<ul style="list-style-type: none"> • plastic surgery of the auditory ossicles, 		
<ul style="list-style-type: none"> • cochlear implant, 		
<ul style="list-style-type: none"> • insulin pump or other drug delivery devices)? 		
<ul style="list-style-type: none"> • intrauterine devices (IUDs) 		
<ul style="list-style-type: none"> • aneurysm clips, vascular clips, 		
<ul style="list-style-type: none"> • prosthesis, implant, embolizing coils 		
<ul style="list-style-type: none"> • stents, bypasses, 		
<ul style="list-style-type: none"> • vascular filters, neurostimulators, 		
<ul style="list-style-type: none"> • biostimulators, artificial valves, 		
<ul style="list-style-type: none"> • dental braces, 		
<ul style="list-style-type: none"> • bone prostheses, implants, 		
<ul style="list-style-type: none"> • metal anastomoses, bone stimulating buckles, 		
<ul style="list-style-type: none"> • metal shrapnel or shavings in the body (especially in the eyes) 		
4. Do you have any other metal items in your body? (If yes, please specify.)		
5. Have you had any surgeries? If so, please list them (including type and date)		
<ul style="list-style-type: none"> • Do you suffer from: 		
<ul style="list-style-type: none"> • kidney disease, 		
<ul style="list-style-type: none"> • asthma, 		
<ul style="list-style-type: none"> • hypertension, 		
<ul style="list-style-type: none"> • heart rhythm disturbances, 		
<ul style="list-style-type: none"> • epilepsy, 		
<ul style="list-style-type: none"> • diabetes, 		

<ul style="list-style-type: none"> • glaucoma? 		
<ul style="list-style-type: none"> • Other than those mentioned above, do you have any other conditions? _____ 		
6. Have you ever had an MRI examination using a contrast agent?		
Have you ever had allergic reactions to any pharmaceuticals? If yes, please specify. _____		
7. Did you experience any allergic reactions after the administration of the contrast agent used during the MRI examination?		
8. If it is necessary to perform an examination with the intravenous administration of a contrast agent, I consent to it.		
For patients undergoing tests under the National Health Fund: On the day of the examination, are you receiving treatment in a hospital, day rehabilitation unit, or psychiatric ward?		
I consent to my data being sent via the ICT system to the email address I have provided, without encryption.		
I consent to the processing of my personal data by Astoria Centrum Medyczne and to sharing this data for marketing and statistical purposes, as well as to receiving commercial information by electronic means. We would like to inform you that providing personal data is voluntary. The data subject has the right to access and correct their personal data, as well as the right to submit a written, reasoned request to discontinue the processing of their data due to their special situation and to object to the processing of their data.		
I authorize / I do not authorize you (with ID number, PESEL: _____) to obtain information about my health condition, health services provided, access to medical records, submit an application for medical records, receive test results, and obtain copies of medical records.		

I declare that I have read the privacy policy applied by Astoria Centrum Medyczne, located at ul. Mehofferera 122, Warsaw. I consent to the processing of my personal data, including the information provided by me in the surveys and forms used by Astoria Centrum Medyczne, as well as the results of tests ordered by me, for the purpose of providing medical services, monitoring, and reporting on the tests performed.

I, the undersigned, declare that I have read and understood the above information. I also declare that I have had the opportunity to ask questions about the planned examination, the associated risks, and the potential complications, and that I received comprehensive answers that I could understand. I am aware of all the risks related to the aforementioned test.

I consent to the examination after making an independent decision, for which I had sufficient time. I also declare that the information I provided is accurate and complete, and that I have not withheld any important details regarding my health, previous treatments, or medications, being aware of the possible health consequences of doing so. I take full responsibility for the information I provide. I confirm that the above information is consistent with the actual situation.

Signature and stamp of
the referring doctor

Patient's full name

Date and signature of the patient