SERVICE IRM BELLEDONNE
83 Avenue Gabriel Péri
38400 SAINT MARTIN D'HERES
www.radiologiebelledonne.fr

PHONE : 04 76 54 01 01
FAX : 04 76 54 92 61

Date of the request: **Date of examination:**

PATIENT IDENTIFICATION

Last name/ First name:
Birth date:
Address:

Phone or Cellphone:
Email address:

Weight :

Valid Patient **Wheelchair Patient** **Patient lying**

IDENTIFICATION OF PRESCRIBING PHYSICIAN

Name:
Address or Service:

Phone.:

ANATOMICAL REGION TO BE EXPLORED

CLINICAL INFORMATIONS:

Turn the page please ⟶

ANSWER THE FOLLOWING QUESTIONS CAREFULLY IN ORDER TO VERIFY THAT THERE IS NO CONTRE INDICATION TO THE EXAMINATION. RETURN THIS FORM COMPLETED WITH YOUR PRESCRIPTION.

	YES, if YES DATE/ REFERENCES	NO
Pace maker/ Implantable cardiac defibrillator**	☐	☐
Heart valves **	☐	☐
Antecedent of intracranial surgery	☐	☐
Neuro surgical clips**	☐	☐
Bypass valves **	☐	☐
Vascular clips / Cave filters **	☐	☐
Vascular Endoprosthesis type **STENT**	☐	☐
Neurostimulator**	☐	☐
Implantable pump (insulin, morphine, other drugs)	☐	☐
Blood glucose implant « FreeStyle LIBRE »	☐	☐
Breast expander (temporary prosthesis)	☐	☐
Are you pregnant?	☐	☐
Do you have orthopedic prostheses? Parts :	☐	☐
Do you have hearing aids (cochlear implants **)	☐	☐
Do you have a metal related risk (eye implant, orthodontic apparatus)	☐	☐
Work in the metallurgy: (risk of having iron needles in your eyes)	☐	☐
Are you claustrophobic (anxiety in an elevator)	☐	☐
Have you ever had an allergic reaction to the contrast agent injected during an MRI scan? **if so, what is the name of this product:**	☐	☐
Are you asthmatic ?	☐	☐
Dates of surgeries on anatomical region to be studied in MRI:		

I certify the accuracy of my information and agree to the MRI examination in the Belledonne MRI department.
Date……..…….... **Patient signature**:

****Provide the certificate from the surgeon or physican ensuring compatibility with an MRI examination**