



CENTRE
DE RADIOLOGIE
BELLEDONNE
www.radiologiebelledonne.fr

SERVICE IRM

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REQUEST FOR MINOR MRI EXAMINATION

Request date:

Expected examination date:

PATIENT IDENTIFICATION

Last name / First name:

Birth date:

Address:

Phone or cellphone:

Email address:

Weight:

Valid Patient

Wheelchair Patient

Patient in bed

IDENTIFICATION OF PRESCRIBING PHYSICIAN

Name:

Address or Service:

Phone:

ANATOMICAL REGION TO BE EXAMINED

CLINICAL INFORMATION

**QUESTIONNAIRE AND CONSENT FORM TO BE COMPLETED AND SIGNED
MANDATORY BEFORE MRI**

**PLEASE ANSWER THE FOLLOWING QUESTIONS CAREFULLY TO VERIFY THAT THERE ARE NO
CONTRAINDICATIONS TO THE EXAMINATION (to carry out the MRI examination safely).
RETURN THIS COMPLETED FORM ALONG WITH YOUR PRESCRIPTION**

	YES <small>(specify date / references)</small>	NO
Pacemaker / Implantable cardiac defibrillator**:	<input type="checkbox"/>	<input type="checkbox"/>
Heart valves ** / Holter monitor:	<input type="checkbox"/>	<input type="checkbox"/>
History of intracranial surgery:	<input type="checkbox"/>	<input type="checkbox"/>
Neurosurgical clips**:	<input type="checkbox"/>	<input type="checkbox"/>
Shunt valves **:	<input type="checkbox"/>	<input type="checkbox"/>
Vascular clips / Vena cava filter** :	<input type="checkbox"/>	<input type="checkbox"/>
STENT-type Endoprosthesis:	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator**:	<input type="checkbox"/>	<input type="checkbox"/>
Implantable pump (insulin, morphine, other drugs):	<input type="checkbox"/>	<input type="checkbox"/>
« FreeStyle LIBRE » Glucose implant:	<input type="checkbox"/>	<input type="checkbox"/>
Temporary Breast expander (prosthesis):	<input type="checkbox"/>	<input type="checkbox"/>
Current pregnancy:	<input type="checkbox"/>	<input type="checkbox"/>
Orthopaedic prosthesis:	<input type="checkbox"/>	<input type="checkbox"/>
<i>Location of the prosthesis:</i>	
Hearing prosthesis (cochlear implant **):	<input type="checkbox"/>	<input type="checkbox"/>
Metallic foreign bodies (eye implant, etc... except dental appliances):	<input type="checkbox"/>	<input type="checkbox"/>
Metalworker (risk of iron filings in the eyes):	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia (anxiety in an elevator):	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had an allergic reaction to contrast agent injected during an MRI scan?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If YES, what is the name of the product:</i>	
Do you have severe renal failure?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma:	<input type="checkbox"/>	<input type="checkbox"/>
Date of surgery in the area to be examined by MRI:	

I, the undersigned, Mr / Mrs / Miss.....
certify that the accuracy of this information and give my consent for the MRI scan for my child..... in the MRI department of the Belledonne Radiology Centre.

Done at.....On..... Parent's signature:

****:** Please provide the relevant card, a copy of the card or the operative report with details of the implanted device (to verify compatibility before the MRI examination).