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| MR tel.: 043/4203469 | | | | | | | | | | | | | | | | | | | | |
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| **Žiadanka na MR vyšetrenie** | | | | | | | | | | | | | | | | | | | | |
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| **Vypísať dvojmo a všetky kolónky!** | | | | | | | | | | | | | | | | | | | | |
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| Priezvisko: |  | | | | | | | | | | | | | | | | | | | |
| Meno: |  | | | | | | | | | | Rodné číslo: | | | |  | | | | | |
| Bydlisko: |  | | | | | | | | | | Kód poisťovne: | | | |  | | | | | |
| Výška: cm, hmotnosť: kg ID prípad:    Odosielajúci lekár (meno, adresa, oddelenie):  Tel./klapka: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Kód odosielajúceho lekára: | | |  |  |  |  |  | |  | | |  |  |  | |  |  |  |  |
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| Kód oddelenia: | | |  |  |  |  |  | |  | | |  |  |  | |  |  |  |  |
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| Predchádzajúce vyšetrenie (CT a MR), Kedy?,Kde? | | | | | | | |  | | | | | | | | | | | | |
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| Pacient objednaný na deň: | | | | | | | | | | Hod: | | | | | | | | | | |
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| Termín vyšetrenia oznámiť na adresu lekára / pacienta (tel.): | | | | | | | | | | | | | | | | | | | | |
| Vyšetrenie v anestéze: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Ktorý orgán má byť vyšetrený? | |  | | | | | | | | | | | | | | | | | | |
| Glomerulárna filtrácia (eGF):  Alergia v anamnéze: | |  | | | | | | | | | | | | | | | | | | |
| Otázka, ktorá má byť vyšetrením zodpovedaná (dif. dg možnosti): | | | | | | | | | | | | | | | | | | | | |
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| Klinická diagnóza (slovom): | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | Štatistický kód: | | | | |  | | | | | |
| Epikríza s výsledkami doterajších vyšetrení: | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Uviesť relatívne kontraindikácie:** kardiostimulátor- aký typ?, kovové implantáty, srdcové chlopne,  kovové svorky, cudzie telesá, inzulínová pumpa, klaustrofóbia, gravidita | | | | | | | | | | | | | | | | | | | | |
| **Priložiť certifikát o 3T MR kompatibilite** kovových materiálov: | | | | | | | | | | | | | | | | | | | | |
| Pred vyšetrením je potrebné odstrániť z kože make-up, očné tiene a rúž. | | | | | | | | | | | | | | | | | | | | |
| Priložte popisy + CD všetkých vyšetrení, ktoré súvisia s diagnózou. | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| Dátum: | | | | | | | | Pečiatka a podpis ošetrujúceho lekára | | | | | | | | | | | | |