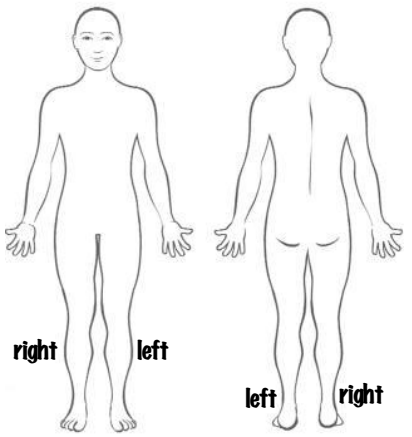
1.5T MRI PRE-SCREENING FORM 1

BIRKBECK/UCL
CENTRE FOR NEUROIMAGING (BUCNI)
This form (ver9) is for primary screening of research subjects. Leave form at BUCNI.

Principal Investigator / Lab:	Subject No (format YYMMDDII):	
Participant: (last name)	(first name)	(middle initial)
Date of birth:	Subject Weight in Kilograms:	
Email address:		
Address : (house no / street)	(city)	(postcode)
Phone: (home)	(work)	(mobile)
GP (name, address, phone number):		



The following questions are to find out about anything that could be hazardous to your safety or that may interfere with the MRI scan. Please answer each of the following. If you check yes, give more information (e.g., type of material, how long ago). Use the diagram to indicate approximately where on your body.

1.	▢ Yes	▢ No	Do you have an implanted medical device? (e.g., heart pacemaker, cochlear implant, metal air tubes, TENS unit, bone stimulator, insulin or other medication pump, automatic defibrillator
2.	▢ Yes	▢ No	Is there a possibility of metal in your head? (e.g., aneurysm clips, CSF shunt, not dental fillings)
3.	▢ Yes	▢ No	Is there a possibility of metal in your eyes? (have you needed an eyewash for metal work?)
4.	▢ Yes	▢ No	Have you had any stents, clips or surgery to any of your vessels (e.g. surgery on blocked arteries, carotid artery vascular clamp, coronary stent, aortic clips, IVS filter, coils to block arteries)
5.	▢ Yes	▢ No	Have you had any metallic dental implants (e.g., posts, crowns) within the last 6 weeks?
6.	▢ Yes	▢ No	Have you had any bone, tendon, spine or joint surgery within the last 6 weeks?
7.	▢ Yes	▢ No	Do you suffer from claustrophobia or do you get uncomfortable in enclosed spaces (e.g., in a lift)
8.	▢ Yes	▢ No	Do you have any medical problems when you lie flat on your back? (breathing, back pain, nausea)
9.	▢ Yes	▢ No	Do you have metal anywhere else in your body? (e.g., spinal rods, dental work, piercings, shrapnel, buckshot, bullets) -- please indicate where on the diagram above
10.	▢ Yes	▢ No	Do you have a tattoo(s), tattooed eyeliner, or tattooed eyebrows?
11.	▢ Yes	▢ No	Have you had any medical condition that prevented you from completing an MRI exam in the past?
12.	▢ Yes	▢ No	Are you suffering from asthma or do you have allergies to any medication you have taken recently?
13.	▢ Yes	▢ No	Have you had any previous surgery? (mark location on your body in the diagram above) Details: Date(s):
14.	▢ Yes	▢ No	Do you have a transdermal medicated patch? (e.g., nicotine, contraceptive, pain relief, heating or cooling patch)
15.	▢ Yes	▢ No	Do you wear a hearing aid, or dentures, or a wig? Do you wear colour contact lenses? (please tick 'Yes" if any of these apply)
16.	▢ Yes	▢ No	[female] Is there any possibility that you may be pregnant?
17.	▢ Yes	▢ No	[female] Do you have an intrauterine device (IUD) containing copper, or a contraceptive diaphragm?
18.	▢ Yes	▢ No	May we contact your G.P. if we notice something unusual in your scan?
19.	▢ Yes	▢ No	Would you like to be informed yourself if something unusual was found in your brain scan?
20.	Initial:		I acknowledge that these scans are not optimized for detection of clinical abnormalities.

Name of person completing form (please print)	Signature	Date
Name of scanner operator reviewing form	Signature	Date