1.5T MRI PRE-SCREENING FORM 1, CHILD

Birkbeck/UCL
Centre for Neuroimaging
This form (ver4) is for primary screening of research subjects. Leave form at BUCNI.

Principal Investigator / Lab _____

Child's Weight in Kilograms _____ Subject Number (YYMMDDII) _____

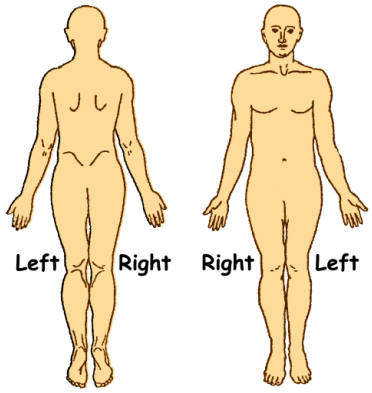
Child's Name _____
Last Name First Name M.I.

Child's Date of Birth _____ Contact Email: _____

Address _____ City _____

Postcode _____ G.P. (see below) _____

Phone _____ _____ _____
Home Work Mobile



⚠ **Some of the following items may be hazardous to your child's safety or 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 child's body.**

1. ☐ Yes ☐ No Does your child 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 child's head? (e.g., aneurysm clips, shunt, not dental fillings)
3. ☐ Yes ☐ No Is there a possibility of metal in your child's eyes? (have they needed an eyewash for metal pieces?)
4. ☐ Yes ☐ No Has your child had any stents, clips or surgery to any vessels (e.g. surgery on blocked arteries, carotid artery vascular clamp, coronary stent, aortic clips, IVS filter, coils to block arteries)
5. ☐ Yes ☐ No Has your child had any metallic dental implants (e.g., posts, crowns) within the last 6 weeks?
6. ☐ Yes ☐ No Has your child had any bone, tendon, spine or joint surgery within the last 6 weeks?
7. ☐ Yes ☐ No Does your child suffer from claustrophobia or get uncomfortable in enclosed spaces (e.g., in a lift)?
8. ☐ Yes ☐ No Does your child have any medical problems lying on his/her back? (breathing, back pain, nausea)
9. ☐ Yes ☐ No Does your child have metal anywhere else in her/his body? (e.g., spinal rods, dental work, piercings, shrapnel, buckshot, bullets) -- please indicate where on the diagram above
10. ☐ Yes ☐ No Does your child have a tattoo(s), tattooed eyeliner, or tattooed eyebrows?
11. ☐ Yes ☐ No Does your child have any medical condition that stopped him or her from having an MRI in the past?
12. ☐ Yes ☐ No Is your child suffering from asthma or have allergies to any medication they have taken recently?
13. ☐ Yes ☐ No Has your child had any previous surgery? (mark location on your body the diagram above)
    Details:_____ Date(s): _____
14. ☐ Yes ☐ No Does your child have a transdermal medicated patch? (e.g., medicated pain relief)
15. ☐ Yes ☐ No Does your child wear a hearing aid, or dentures, or a wig?
16. ☐ Yes ☐ No [female] Is there any possibility that your child may be pregnant?
17. ☐ Yes ☐ No May we contact your G.P. if we notice something unusual in your child's scan?
18. [Initial] _____ I acknowledge that these scans are *not* optimized for detection of clinical abnormalities.

_____ _____ _____/____/____
Name of parent/guardian completing form (please print) Signature Date

_____ _____ _____/____/____
Name of safety personnel reviewing form Signature Date