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| **MRI PRE-SCREENING FORM, ADULT**  **SCANNER:** Click here to enter text.(1.5T or 3T) | | | | | | | | Birkbeck/UCL  Centre for Neuroimaging This form is for primary screening of  research subjects. Leave form at BUCNI | | |
| Principal Investigator / Lab:  Click here to enter text. | | | | | | | Subject No (format YYMMDDII: | | | |
| Participant: | | (Last name)  Click here to enter text. | | | (First name)  Click here to enter text. | | | | | (Middle initial)  Click here to enter text. |
| Date of Birth  Click here to enter text. | | | Subject Height in cm:  Click here to enter text. | | | | Subject Weight in kg:  Click here to enter text. | | Email address:  Click here to enter text. | |
| Address: | Click here to enter text.  (House no / street) | | | (City) | | (Postcode) | | | Phone:  Click here to enter text. | |
| GP (name, address, phone number):  Click here to enter text. | | | | | | | | | | |

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, please provide more information.

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| 1. | Yes | No | Do you feel sick today? |
| 2. | 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) |
| 3. | Yes | No | Is there a possibility of metal in your head? (e.g., aneurysm clips, CSF shunt, not dental fillings) |
| 4. | Yes | No | Is there a possibility of metal in your eyes? Have you needed an eyewash for metalwork? |
| 5. | 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) |
| 6. | Yes | No | Have you ever had any surgery?  **Details:**Click here to enter text. **Date(s):**Click here to enter text. |
| 7. | Yes | No | Do you have any metallic dental implants (e.g., posts, crowns, dentures, bridges)? |
| 8. | Yes | No | **Within the last 6 weeks,** have you had any dental fillings? |
| 9. | Yes | No | **Within the last 6 weeks,** have you had any bone, tendon, spine, or joint surgery? |
| 10. | Yes | No | Do you have metal anywhere else in your body? (e.g., spinal rods, dental work (i.e., retainers), piercings, shrapnel, buckshot, bullets). |
| 11. | Yes | No | Do you have a transdermal medicated patch? (e.g., nicotine, contraceptive, pain relief, heating/cooling patch) |
| 12. | Yes | No | Do you have tattoo(s), tattooed eyeliner, or tattooed eyebrows/microblading? **If yes:** |
|  | *Yes* | *No* | 1. *Was it professionally applied by a trained tattoo artist?* |
|  | *Yes* | *No* | 1. *Do you have any thermoregulatory problems or skin insensitivity?* |
|  | *Yes* | *No* | 1. *Are you willing and able to use a squeezable bulb to alert the MRI operator that your tattoo is tingling or heating?* |
|  | *Yes* | *No* | 1. *Is the tattoo more than six weeks old?* |
| 13. | Yes | No | Do you wear a hearing aid, and/or dentures? |
| 14. | Yes | No | Do you wear a wig, hair-extensions, and/or a veil? |
| 15. | Yes | No | Are you wearing colour contact lenses and/or any makeup (i.e., mascara, eyeliner, eyelashes, nail polish)? |
| 16. | Yes | No | Are you wearing any bra or sports bra, or any antimicrobial clothing? Are there any loose metal parts on your clothing (e.g. metal collar stays)? -- *Ask if you are not sure please* |
| 17. | Yes | No | Do you have any medical problems when you lie flat on your back? (e.g., breathing, back pain, nausea) |
| 18. | Yes | No | Are you suffering from asthma, or do you have allergies to any medication you have taken recently? |
| 19. | Yes | No | Do you suffer from claustrophobia, or do you get uncomfortable in enclosed spaces? (e.g., in a lift) |
| 20. | Yes | No | Have you had any medical condition that prevented you from completing an MRI exam in the past? |
| 21. | Yes | No | [*female*] Is there any possibility that you may be pregnant? |
| 22. | Yes | No | [*female*] Do you have an intrauterine device (IUD) containing copper, a contraceptive diaphragm, or a contraceptive implant? |
| 23. | Yes | No | Do you have any other medical device / non-medical device on your body or implanted not covered in the questions above? (e.g., sub-dermal chip, sensor, endoscopy pill, etc.) |
| 24. | Yes | No | May we contact you and help you liaise with your G.P. if we notice something unusual in the scan? |
| 25. | Yes | No | Would you like to be informed yourself if something unusual was found in your brain scan? |
| 26. | *Initial:* |  | *I acknowledge that these scans are not optimized for detection of clinical abnormalities.* |
| 27. | *Initial:* |  | *I acknowledge that BUCNI will store data from my scan for 10 years.* |

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