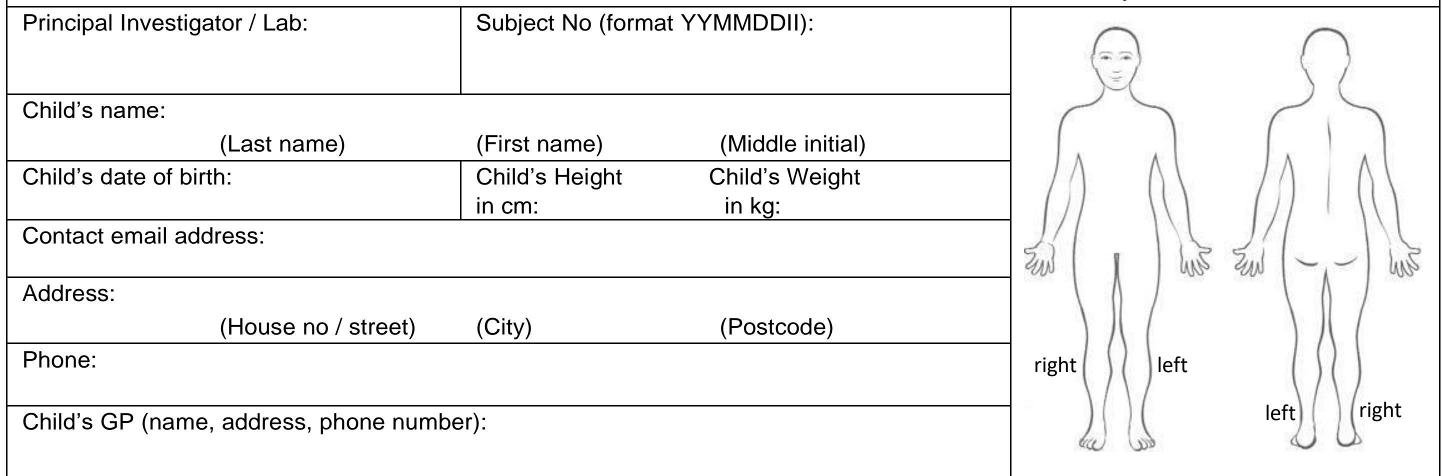
MRI PRE-SCREENING FORM, CHILD

SCANNER: ________________ (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:	Subject No (format YYMMDDII):	
Child's name: (Last name)	(First name)	(Middle initial)
Child's date of birth:	Child's Height in cm:	Child's Weight in kg:
Contact email address:		
Address: (House no / street)	(City)	(Postcode)
Phone:		
Child's 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	Does your child feel sick today?
2.	▢ 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)
3.	▢ Yes	▢ No	Is there a possibility of metal in your child's head? (e.g., aneurysm clips, CSF shunt, not dental fillings)
4.	▢ Yes	▢ No	Is there a possibility of metal in your child's eyes? Has your child needed an eyewash for metalwork?
5.	▢ Yes	▢ No	Has your child had any stents, clips, or surgery to any of their vessels (e.g., surgery on blocked arteries, carotid artery vascular clamp, coronary stent, aortic clips, IVS filter, coils to block arteries)
6.	▢ Yes	▢ No	Has your child ever had any surgery? -- *please indicate where on the diagram above* Details: Date(s):
7.	▢ Yes	▢ No	**Within the last 6 weeks,** has your child had any metallic dental implants (e.g., posts, crowns)?
8.	▢ Yes	▢ No	**Within the last 6 weeks,** has your child had any bone, tendon, spine, or joint surgery?
9.	▢ Yes	▢ No	Does your child have metal anywhere else in their body? (e.g., spinal rods, dental work (i.e., retainers), piercings, shrapnel, buckshot, bullets) -- *please indicate where on the diagram above*
10.	▢ Yes	▢ No	Does your child have a transdermal medicated patch? (e.g., medicated pain relief, heating/cooling patch)
11.	▢ Yes	▢ No	Does your child have a tattoo(s), tattooed eyeliner, or tattooed eyebrows/microblading? -- *please indicate where on the diagram above*
12.	▢ Yes	▢ No	Does your child wear a hearing aid, or dentures?
13.	▢ Yes	▢ No	Does your child wear a wig, hair-extensions, or a veil?
14.	▢ Yes	▢ No	Is your child wearing colour contact lenses or any makeup (i.e., mascara, eyeliner, or cosmetic eyelashes)?
15.	▢ Yes	▢ No	Is your child 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.*
16.	▢ Yes	▢ No	Does your child have any medical problems when they lie flat on their back? (e.g., breathing, back pain, nausea)
17.	▢ Yes	▢ No	Is your child suffering from asthma, or have allergies to any medication they have taken recently?
18.	▢ Yes	▢ No	Does your child suffer from claustrophobia, or get uncomfortable in enclosed spaces? (e.g., in a lift)
19.	▢ Yes	▢ No	Does your child have any medical condition that prevented them from completing an MRI exam in the past?
20.	▢ Yes	▢ No	[*female*] Is there any possibility that your child may be pregnant?
21.	▢ Yes	▢ No	May we contact you and help you liaise with your child's G.P. if we notice something unusual in the scan?
22.	▢ Yes	▢ No	Would you like to be informed yourself if something unusual was found in your child's brain scan?
23.	*Initial:*		*I acknowledge that these scans are not optimized for detection of clinical abnormalities.*
24.	*Initial:*		*I acknowledge that BUCNI will store data from my child's scan for 10 years.*

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