

# 3T VOLUNTEER MRI SCREENING FORM



Please carefully check the following. Some items can interfere with MR examinations and may be hazardous to your safety. Clearly mark your answer with a circle and add any relevant information. To ensure your safety we must ask for your biological sex, weight and height. Your answers will be kept strictly confidential.

**Volunteer name** \_\_\_\_\_ **Sex** \_\_\_\_\_

**Date of birth** \_\_\_\_\_ **Weight** \_\_\_\_\_ **kg** **Height** \_\_\_\_\_ **cm**

## IF YOU HAVE ANY QUESTIONS THEN PLEASE ASK US BEFORE YOUR SCAN

Do you have a heart pacemaker or pacing wires?	YES	NO
Have you had any heart surgery (e.g. coronary stent, PFO closure)?	YES	NO
Have you had any surgery to your head including eyes / ears / brain?	YES	NO
Have you had any surgery to your neck or spine?	YES	NO
Do you have any implanted devices (e.g. aneurysm clip, hydrocephalus shunt, nerve stimulator, cochlear implant, mesh)?	YES	NO
Have you had any operations involving metallic pins / plates / screws / wires?	YES	NO
Have you had any surgical procedures or endoscopy in the last 6 weeks? (Please write below)	YES	NO
Have you <b>ever</b> had any other surgical procedures of any kind? (Please write below)	YES	NO
Have you <b>ever</b> sustained any injuries involving metal to the eyes or other part of the body (e.g. from drilling, grinding or welding)?	YES	NO
Have you ever had a serious accident or injury (e.g. road traffic accident, industrial accident, explosion injury, shooting injury or shrapnel injury)?	YES	NO
Have you ever had a fit or blackout, or do you suffer from epilepsy or diabetes?	YES	NO
Do you have any of the following (if yes please circle):		
Body piercing, eye makeup, coloured contact lenses	Hearing aid, wearable medical device (e.g. drug pump, glucose monitor)	Tattoos (including cosmetic)
Dentures, dental braces, dental implant, dental bridge	Medicated skin patch (e.g. pain, HRT, nicotine, contraceptive)	Artificial limb, prosthesis, splint, brace or support
FOR WOMEN OF CHILDBEARING AGE:	Do you have an IUD (coil)?	YES NO
	Could you be pregnant?	YES NO
Are you wearing any clothing, including underwear, that contains metallic threads or has been silver impregnated (e.g. anti-microbial)?	YES	NO
Do you understand that this is a research scan and is not useful for diagnosis?	YES	NO
Have you removed your jewellery, hairgrips, hearing aids, watch, spectacles, keys and coins?	YES	NO

**Volunteer / Guardian signature** \_\_\_\_\_ **Date of study** \_\_\_\_\_

**Screened by** \_\_\_\_\_ **Signature** \_\_\_\_\_ **Consent sighted** \_\_\_\_\_

**IMPORTANT: NO METAL OBJECTS TO BE TAKEN INTO THE MAGNET ROOM**

**Notes**

**For scans using contrast agent only:** *(please ask a member of staff if you don't know whether your scan will involve contrast agent)*

Have you had MR contrast agent before? (please leave blank if unknown)	YES	NO
Are you aware of any problems with your kidneys?	YES	NO
Do you have any allergies to medications? If yes please give details	YES	NO
Are you currently breast-feeding?	YES	NO