

3T VOLUNTEER MRI SCREENING FORM



Please carefully check the following as some items can interfere with MR or be hazardous to your safety. Mark your answer with a circle and add any relevant information. Safety calculations made by the scanner require us to input your weight, height and sex assigned at birth. **Your answers will be kept strictly confidential.**

Volunteer name _____ Sex _____

Date of birth _____ Weight _____ kg Height _____ cm

I understand these questions are used to determine if it is safe to take part in the study and may be looked at by designated individuals from the University of Oxford. If I am not scanned these details will be destroyed. If I am scanned these details will be securely stored for up to 5 years and then destroyed.

Please initial if you agree

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, heart valve replacement, 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 ever had any other surgical procedures of any kind, however minor or as a child? (Please write below)	YES	NO
Have you ever 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 or industrial accident, explosion, shooting 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)	Dentures, dental braces, dental implant, dental bridge
Tattoos (including cosmetic)	Artificial limb, prosthesis, splint, brace or support	IUD (contraceptive coil) If yes please state type:
Medicated skin patch (e.g. pain, HRT, nicotine, contraceptive)		
Could you be pregnant?	N/A	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 _____

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