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| imagesGU | **Clinical Research MRI Facility** **Screening Form**MR Controlled Access Area including Scanner Room | **NHS_RS_logo2** |

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| **Assessed for** **1.5T / 3T / 7T**Please circle |
| **Staff screening**Please tick |

Name: Address:

Date of Birth:

CHI:

Phone number:

GP details:

Study name: R&D number: Investigator:

 Study ID: Weight: Height:

|  |  |
| --- | --- |
| **Have you ever:**Had a cardiac pacemaker, implanted defibrillator or pacing wires? Had any surgery/procedure to your heart? * If yes, give details……………………………………………….………………………………………………………………….............…………………..

Had any surgery on your neck, head, brain or eyes? * If yes, give details……………………………………………….…………………………………………………….............………………………………..

Had any surgery involving the use of metal implants, plates, or clips?* If yes, give details……………………………………………….………………………………………………….............…………………………………..

Had any implanted, attached or ingested electronic, mechanical or magnetic devices?* If yes, give details……………………………………………….……………………………………………….............……………………………………..

Had any other surgery?* If yes, give details………………………………………………………………………………............……………………………………………………….

Had metallic injuries or metal fragments in your eyes /other parts of the body? Have metal dentures/dental plate, hearing aid or wig?Wear a false limb, calliper or brace? Have any tattoos, permanent makeup or body piercing? Wear any type of skin patch? * If yes, give details………………………………………………………………………………............……………………………………………………….

**Contrast examinations – 3T only:**Have any kidney problems, kidney failure or ever had dialysis?Have asthma, eczema, hayfever or any known allergies?* I will accept a contrast agent injection if required.

Females:Could you be pregnant? * LMP date: ……………………………………….
* Have you been sterilised or have an IUD fitted?
* **Contrast examination**: Are you breast feeding?
 |  YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NO YES NOYES NOYES NOYES NOYES NO YES NO |

Before entry into the examination room all metallic objects must be removed:Metal tools, scissors, keys, watches, pagers, credit cards, coins, hair clips, hearing aid, jewellery and all other metallic items upon my person.

I have read and understood the contents of this form and confirm that the answers to the above safety questions are correct to the best of my knowledge. I have had the opportunity to ask questions about the MRI procedure that I am about to undergo**.**

**Staff/participant/patient/visitor:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Authorised Scanning Staff Member:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**MRI Drug and Contrast Administration Record**

**Contrast Details**

eGFR \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of eGFR \_\_\_\_\_\_\_\_\_\_\_\_*If eGFR <59ml/min consult Supervising Doctor*

Contrast Label: ........................................... Expiry Checked By: ..................................................

Total Contrast Injected: ...........................................

Signature of Person Administering Contrast: ..................................................................................

Images Checked for Contrast

Drug reaction/ extravasation details:

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**Sequences**

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| --- | --- | --- | --- |
| Sequence Name | Checked | Sequence Name | Checked |
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**Post Processing**

PACS Sent / Checked

CRIS Yes/No

WHITE FOLDER Yes/No

UOG Sent / Checked

Daily Activity Yes/No

DVD No ………………………………… Sent/Checked

Upload ………………………………… SFTP/Web Upload/DVD Sent

Data transmittal form (or similar) none/completed ………./uploaded ……....

Spectroscopy Saved to Workstation and Hard Drive Yes/No