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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:

|  |  |
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| **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 NO  YES NO  YES NO  YES NO  YES 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