scannexus

Safety screening form MRI
Version 2.1

I have understood the following questions and answered honestly:

- Do you have an active implant? ☐ Yes ☐ No
  (pacemaker, neurostimulator, insulin pump, ossicle prosthesis, or residual leads)
- Do you have any other foreign objects in your body, except dental fillings or crowns? ☐ Yes ☐ No
  (e. g. clips on blood vessels, metal splinters in the eye or body as consequence of shooting/accident/metal worker, orthopedic implants, braces, metal wire behind the teeth, mechanical contraception spiral)

  If yes, what kind of foreign object?
- Have you had surgery to your brain, head? ☐ Yes ☐ No
- Do you suffer from epilepsy? ☐ Yes ☐ No
- Do you suffer from any known heart rhythm disorder? ☐ Yes ☐ No
- Do you have circulatory problems? ☐ Yes ☐ No
- Are you diabetic? ☐ Yes ☐ No
- Do you suffer from claustrophobia? ☐ Yes ☐ No
- Are you pregnant or do think that you might be? ☐ Yes ☐ No
- Do you wear jewelry/piercings that cannot be taken of? ☐ Yes ☐ No
- Do you have tattoos or permanent eye make-up? ☐ Yes ☐ No
- Are you using medical plasters (e.g. nicotine) that cannot be taken of? ☐ Yes ☐ No

I have been informed to satisfaction concerning the MRI safety. I had the possibility to ask questions concerning MRI safety. All my questions are answered to my satisfaction.

I agree with being scanned:

Last name:

First name:

Middle name (if any):

Today's date:

Date of birth:

Height (cm):

Weight (kg):

Signature:

To be filled out by the researcher

Name: MR System: Project number:

I declare that the person mentioned above has been informed orally and in writing about the MRI scan and has given their informed consent about the project mentioned above. I also declare that premature termination of participation by the person mentioned above will be of no influence on the care he or she will receive.

Function:

Signature: Date and time of scan: