

SCAN SUBJECT EXIT FORM

Lucas Center 3.0T MR Research Studies

 PLEASE PRINT LEGIBLY

 PLEASE COMPLETE ALL SECTIONS BEFORE EXITING 3T SUITE

Date _____ Researcher name _____ PI name _____

Anatomy scanned: Brain Chest Abdomen C Spine L Spine Shoulder
 Neck Breast Pelvis T Spine Knee Other: _____

Coil: GE product head fMRI coil Posthead Helmethead Other _____

Scan subject name _____ Birthdate _____

Social security # _____ Phone # (w) _____ (h) _____

Address/City/St _____

Current medical conditions? _____

Medications currently using? _____

Current medical treatments? _____

On a scale from 1 (**most** comfortable) to 5 (**least** comfortable):

How comfortable were you before the scan?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
How comfortable were you during the scan?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
How comfortable were you after the scan?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

During the MR exam did you experience any of the following:

Nervousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sleepiness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscle Stimulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heat Sensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Changes in vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unusual Taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other _____

Signature of Scan Subject _____