SCREENING FORM FOR PARTICIPANTS AFTER THE MRI PROCEDURE

Ghent Institute for Functional and Metabolic Imaging

RESEARCHER'S NAME:	
STUDY DATE:	STUDY NR:
SCAN DURATION:	ACQUIRED SEQUENCES: ☐ MPRAGE ☐ fMRI ☐ DTI ☐ ASL ☐ Other:

PARTICIPANT'S NAME:
DATE OF BIRTH:


This is a checklist that questions very rare but possible side effects of an MRI scan.

Did you/did you not feel any of these side effects?	**YES**	**NO**	**COMMENT**
Claustrophobia?	☐	☐	
Dizziness?	☐	☐	
Nausea?	☐	☐	
Warmth?	☐	☐	
Coldness?	☐	☐	
Metal taste?	☐	☐	
Headache?	☐	☐	
Musle contractions?	☐	☐	
Other?			

Statement of the participant: ***"I declare that the provided information is correct and complete.."***

Participant's signature and date:

Researcher's signature and date: