# Report of abnormal or uncomfortable sensations during MRI-measurements

If your subject felt something that was uncomfortable, painful, or abnormal and surprising (e.g., warming-up, skin tingling, numbness, dizziness etc.) during fMRI/MRI measurements, please, fill this form when applicable and return it as soon as possible to AMI Centre office (Otakaari 5 I, 2nd floor, room IM213 or IM212). If necessary, you can add additional handwritten appendices to this report.

<table>
<thead>
<tr>
<th>Measurement date:</th>
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</thead>
<tbody>
<tr>
<td>Measurement time:</td>
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<tr>
<td>Subject number on the console (no identification):</td>
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<tr>
<td>Used imaging coil (e.g., 32ch, 20ch etc.):</td>
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<tr>
<td>Name of the pulse sequence:</td>
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<tr>
<td>Subject position (circle the correct one): supine, prone, left decubitus / right decubitus</td>
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<td>TR:</td>
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<tr>
<td>Matrix size:</td>
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<tr>
<td>Slice orientation:</td>
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<tr>
<td>Duration of measurement:</td>
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<tr>
<td>Other information:</td>
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<tr>
<td>Subject’s age:</td>
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</tbody>
</table>

Subject’s description of the abnormal and/or uncomfortable sensations (as detailed as possible):

__________________________
__________________________
__________________________

Was the quality of the MR images abnormal (did the images show, e.g., stripes, bright spots, noise, geometric distortion, signal loss or other types of artifacts):

__________________________
__________________________
__________________________

Were these sensations ceased when the measurement was finished:

__________________________
__________________________
__________________________
Did these sensations leave any visible signs (e.g., redness of the skin):  

____________________________________________________________________________________

Did the subject abort the measurement because of these sensations:  

____________________________________________________________________________________

How does the subject judge the level of uncomfortableness related to the sensations (on a scale from 1 to 10, where 1 = not uncomfortable at all and 10 = extremely uncomfortable):  

____________________________________________________________________________________

How does the subject judge the level of pain related to the sensations (on a scale from 1 to 10, where 1 = not painful at all and 10 = extremely painful):  

____________________________________________________________________________________

Did subject’s arms or legs form a closed loop during the measurement:  

____________________________________________________________________________________

Was there any metal (prostheses, clips, jewelry etc.), tattoos or permanent makeup on subject’s body or clothing:  

____________________________________________________________________________________

What was subject’s clothing like during the measurement (overalls, pyjamas, own clothes etc.):  

____________________________________________________________________________________

How was subject’s hearing protected during the measurement (ear plugs, earmuffs etc.):  

____________________________________________________________________________________

What kind of stimulus hardware/equipment was used during the measurement:  

____________________________________________________________________________________

Were there any other devices used, which or whose wires were installed/mounted on the subject:  

____________________________________________________________________________________

Were any other devices used, which or whose wires were in or close to the magnet bore:  

____________________________________________________________________________________

Were there any "yes" or "don’t know" answers in the safety screening form that the subject filled? Please, list all the “yes" or “don’t know” answers here:  

____________________________________________________________________________________
What was subject’s health like before the measurement (did she/he have, e.g., sniffle, fever, sickness, any pains etc.): ________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Any other comments or observations: ________________________________________

________________________________________________________________________

________________________________________________________________________

Date: ____________________________________________________________________

Printed name of the principal investigator: ________________________________

Signature of the principal investigator: _________________________________

Contact information: ____________________________________________________