



*mark 3 MRI/MRA Scan Review form for MMA Competitors

TO BE COMPLETED BY A CONSULTANT RADIOLOGIST OR NEURORADIOLOGIST

Please return WITH corresponding MRI/MRA scan reports to: records@safemma.org

Competitor Name: _____

Date of birth: _____

Reviewing Radiologist Name: _____

Qualifications: _____

Doctor Registration Number: _____

Practice address: _____

Telephone number: _____

Email address: _____

PROTOCOLS

TO BE CONDUCTED ONCE EVERY 3 YEARS <small>*unless otherwise referred</small> MRI brain Minimum 1.5 Telsa and minimum 5mm cuts Axial T1, T2, Flair and T2star (or gradient echo or SWI) Sagittal T1 and FLAIR Coronal FLAIR and T2star (or gradient echo or SWI)	TO BE CONDUCTED ONCE ONLY <small>*unless otherwise referred</small> MRA intracranial blood vessels
Protocol conducted: YES <input type="checkbox"/> NO <input type="checkbox"/> Signed/initialled (radiologist)	Protocol conducted: YES <input type="checkbox"/> NO <input type="checkbox"/> Signed/initialled (radiologist)

REVIEW

I confirm that no abnormalities were found outside of normal variation: <small>PLEASE REPORT: white matter T2 hyperintensities, cavum septi pellucidi, brain atrophy, pituitary changes and dilated VR spaces</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Date of scan(s): _____	
Additional comments:	

Signed (radiologist): _____

Date: _____