

Coil Evaluation Form

Company Name: _____

Date: _____

Point of Contact: _____

Telephone _____

Coil Description: _____

MRI System: _____

Coil Part Number: _____

Frequency of System: _____

Coil Serial Number: _____

System Field Strength: _____

Issues related to this coil: (Check all that apply)

- Mechanical** **Will not scan** **SNR** **Artifact** **Homogeneity**
- Mechanical:** Housing Output cable Connector Other _____
- Will not scan:** TR Driver fault Loss of signal Coil ID
- SNR:** Grainy image Poor contrast
- Low Signal:** Channel _____ SNR value _____ Specification _____
- Artifact:** Localized Bright Area Dark Hole Shading
- Homogeneity:** Poor Uniformity Fat saturation

Is this problem Intermittent? Yes No

Did you purchase this product new? _____ If not, how long have you been using it? _____

Has this coil been previously serviced? Yes No Unknown

If so, who serviced previously? _____

If so, what was the problem with the coil? _____

Brief description of part failure:
