

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR RESEARCH

Date ____/____/____

Name or Coded Study Number _____ Age _____ Height _____ Weight _____

Birth Sex: Male ☐ Female ☐

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes

If yes, please indicate the date and type of surgery:

Date ____/____/____ Type of surgery _____

Date ____/____/____ Type of surgery _____

2. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes

If yes, please describe: _____

3. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

4. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

5. Are you allergic to any medication? ☐ No ☐ Yes

If yes, please list: _____

6. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes

7. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? ☐ No ☐ Yes

If yes, please describe: _____

For female subjects

8. Are you pregnant or suspect that you are pregnant? ☐ No ☐ Yes

9. Are you currently breastfeeding? ☐ No ☐ Yes

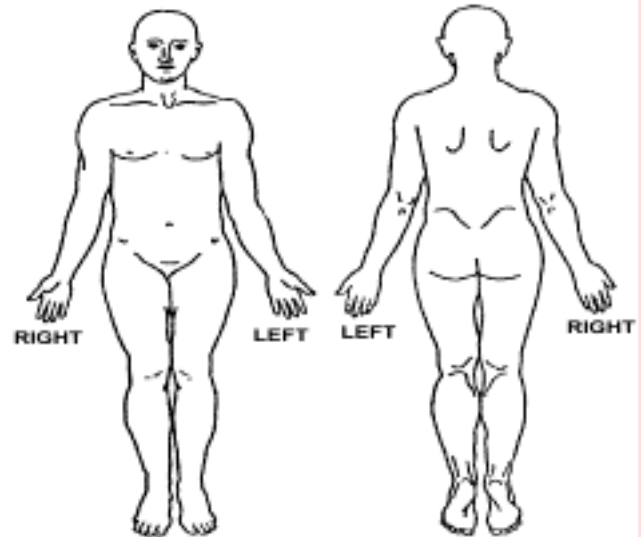


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Researcher **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- | | | |
|--|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electronic implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetically-activated implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulation system |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal cord stimulator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes or wires |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/bone fusion stimulator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic, or other ear implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or other infusion pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug infusion device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart valve prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid spring or wire |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial or prosthetic limb |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metallic stent, filter, or coil |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intraventricular) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port and/or catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation seeds or implants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swan-Ganz or thermodilution catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medication patch (Nicotine, Nitroglycerine) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metallic fragment or foreign body |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wire mesh implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (e.g., breast) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical staples, clips, or metallic sutures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement (hip, knee, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD, diaphragm, or pessary |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures or partial plates |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo or permanent makeup |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing jewelry or false/fake eyelashes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing aid |
| <i>(Remove before entering MR system room)</i> | | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other implant _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Breathing problem or motion disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Claustrophobia |

**Please mark on the figure(s) below
the location of any implant or metal
inside of or on your body.**



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Researcher if you have any question or concern **BEFORE you enter the MR system room.**

NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Form Completed By: ☐ Subject ☐ Relative ☐ Nurse _____
Print Name or Coded Subject Number Relationship to subject

Form Information Reviewed By: _____
Print name Signature

☐ MRI Technologist ☐ Researcher ☐ Other _____