

MAGNETIC RESONANCE (MR) PRE-SCREENING FORM FOR PARTICIPANTS

Principal investigator/Lab _____ Subject number _____ Height _____ Weight _____

IRB protocol # _____ Date of MRI study ____/____/____ Time of MRI study _____



WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment or MR system room if you have any question or concern regarding an implant, device, or object.

1. Yes No **Do you currently have, OR have you ever had a pacemaker or defibrillator?**
 2. Yes No **Do you currently have, OR have you ever had a neurostimulator ex: (Vagus nerve stimulator, Bone growth stimulator, Deep brain stimulator etc.) or any other implanted stimulator?**
 3. Yes No **Do you have an infusion pump or pain pump or continuous glucose monitor?**
 4. Yes No **Do you have an implanted loop recorder? If yes, what make/model?**
 5. Yes No Have you ever been injured anywhere in your body by a metal object or foreign body?
 6. Yes No **Have you ever had metal removed from your eye?**
 7. Yes No **Have you ever worked with metals or welded without a shield?**
 8. Yes No Do you have any aneurysm clips or coils anywhere in your body? If yes, what make/model?
 9. Yes No Do you have any stents or filter anywhere in your body? If yes, where?
 10. Yes No **Do you have a cochlear implant, stapes implant, or hearing aid attached with a magnet?**
 11. Yes No **Do you have Harrington Rods? (Commonly used for scoliosis)**
 12. Yes No Do you have a VP shunt, CSF shunt, or eye shunt? If yes, what make/model?
 13. Yes No **Have you had a colonoscopy, endoscopy, or swallowed a pill camera in the last month?**
 14. Yes No **Are you pregnant or actively trying to become pregnant?**
 15. Yes No **Do you weigh more than 300lbs (135kg)?**
 16. Yes No **Do you have braces or non-removable metal dental work?**
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17. Yes No Do you have a glucose monitor or insulin pump? (You will be required to remove this prior to the MRI)
 18. Yes No Do you have any metal from a spinal surgery?
 19. Yes No Do you have any metal rods or screws or orthopedic implants?
 20. Yes No Do you have any heart valves or annuloplasty rings?
 21. Yes No Do you have any surgical staples, sutures, or mesh?
 22. Yes No **Do you have any prosthesis? (penile, eye, arm, leg, etc.)**
 23. Yes No Do you have an IUD that may contain copper?
 24. Yes No Do you have any transdermal patches? If yes, where are they, and are they backed with foil? (These might need to be removed prior to the MRI)
 25. Yes No Do you have any silver containing cream or spray on hair dye? (This will need to be washed off prior to the MRI)
 26. Yes No Do you wear hearing aids or dentures? (These will need to be removed prior to the MRI)
 27. Yes No Do you have any piercings? (These will need to be removed prior to MRI)
 28. Yes No Any other implant (internal or external) not previously listed? If yes, please list: _____
 29. Yes No **Do you have any cosmetic tattoos ex: (eyebrows, eyeliner, lips, freckles, etc.)**
 30. Yes No Do you suffer with asthma or allergies to any animals or hay?
 31. Yes No Have you had any medical condition that has prevented you from completing an MRI exam in the past?
 32. Yes No Do you suffer with claustrophobia or anxiety?
 33. Yes No Do you have any medical problems when you lie flat on your back?
 34. Yes No **Are you able to lay still for 30-60 minutes?**
 35. Yes No It is a requirement to change out of your clothes (including bras and underwear) and into the provided scrubs, are you able and willing to do so?

Please list ALL pervious surgeries AND metal in your body (give details and dates)

Surgery or Metal _____	Date ____/____/____
Surgery or Metal _____	Date ____/____/____
Surgery or Metal _____	Date ____/____/____
Surgery or Metal _____	Date ____/____/____
Surgery or Metal _____	Date ____/____/____
Surgery or Metal _____	Date ____/____/____

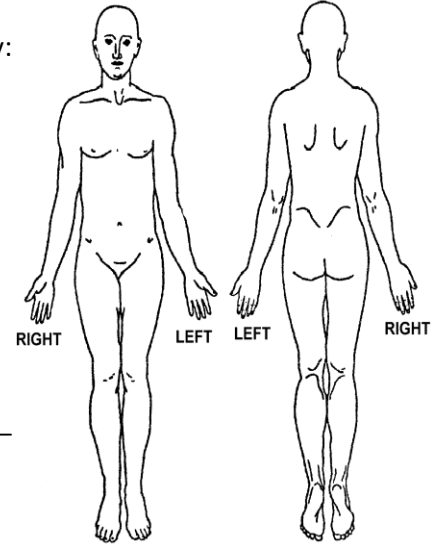
Please indicate on the diagram the location of metal in your body:

Signature of participant: _____

Date: ____/____/____

Actions taken:

If any responses above are checked "yes", detail here the actions taken before scanning subject.



I certify that I have screened this subject, and there are no contraindications to entering the MRI scanner room. This form is valid only on the day it is completed.

Signature of MRI scan operator

Printed name of MRI scan operator

____/____/____
Date