

MAGNETIC RESONANCE (MR) SCREENING FORM FOR PARTICIPANTS

Name: _____ Scan date: _____ Date of birth: _____ Male Female

Age _____ Height _____ Weight _____ Person completing form (if different than above): _____

1. Have you had a prior MRI scan? No Yes
 2. Have you experienced any problem related to a previous MRI scan or MR procedure? No Yes
If yes, describe: _____
 3. Have you had an injury to the eye involving a metal object or fragment (e.g. metallic slivers, shavings, foreign body, etc.)? If yes, describe: No Yes
 4. Have you ever been injured by a metal object or foreign body (e.g., BB, bullet, shrapnel, etc.)? If yes, describe: No Yes
 5. Do you have braces or a permanent retainer? No Yes
 6. Do you have dentures, partial plates or dental bridge? No Yes
 7. Do you wear corrective lenses or contacts? No Yes
- For female participants:**
8. Date of last menstrual period: _____/_____/_____ Post menopausal? No Yes
 9. Are you pregnant or experiencing a late menstrual period? No Yes
 10. Are you taking oral contraceptives, use an IUD or diaphragm or other implantable birth control? No Yes
If yes, describe: _____

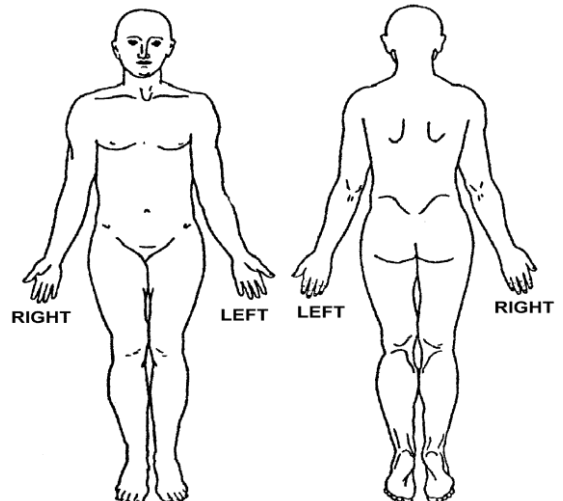


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR scan. **Please complete this entire form. Do not enter** the MR room or environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist **BEFORE** entering the MR room. The MR magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- Yes No Tattoo or permanent makeup Date of most recent: _____
- Yes No Body piercing jewelry (remove before entering MR room)
- Yes No Any metal fragment or foreign body
- Yes No Ankle monitoring bracelet
- Yes No Hearing aid (remove before entering MR room)
- Yes No Breathing problems
- Yes No Motion sickness
- Yes No Claustrophobia
- Yes No Pessary (e.g. bladder sling) Type: _____
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Medication patch (nicotine, nitroglycerine, etc.)

Please mark the location of any implant, metal or tattoo in or on your body on the figure(s) below.



Have you had ANY prior surgery or operation? No Yes

List all: _____

If yes, indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implantable cardioverter defibrillator (ICD)

TURN OVER

- Yes No Any type of electronic, mechanical or magnetic implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Artificial heart valve
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metal stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or other implanted catheter
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g. breast)
- Yes No Surgical staples, clips, or metal sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No Other implant; describe: _____



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 and bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners and/or metallic threads. You will be asked to change into a hospital gown or scrubs for your MRI. A locker will be provided for your personal belongings. You will be required to wear headphones during the MR procedure to prevent possible problems or hazards related to acoustic noise.

MRN STAFF: All participants must be screened for MRI safety purposes prior to scheduling. YES responses must be further researched by asking questions and, if necessary, obtaining written documentation of any past surgeries, injuries or implants. This documentation should be provided to the MRI tech for review and approval; MRI techs will consult with the Medical Director as needed.

- Participant is ≤ 10 y.o.:** a parent is required to complete and sign the safety screening form for the child.
- Participant is 11 -17 y.o.:** the child should complete this form and the parent must verify the child's responses (unless a waiver of parental permission has been granted by the IRB) either in person (if the parent presents with the child for the scan), over the phone (if parent is giving phone consent), or by fax/email (parent can be faxed/emailed the screening form and they can return it completed/signed). If parent is not available to sign, parent verification must be otherwise documented (including the name of the parent and date info was verified). NOTE: parent verification need only to occur before the first scan, if multiple scans are being performed.

If pregnancy test completed: Results: _____ RA/Tech Initials: _____

Name of Screening RA/Tech	Date
Signature of Participant	Date
Signature of Parent (for participant age 17 or younger)	Date