

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.)? No Yes
If yes, describe: _____


5. Do you have braces or permanent retainer? No Yes

6. Do you have dentures, partial plates or dental bridge? No Yes

7. Do you have a history kidney disease or are you on dialysis? No Yes

8. Are you pregnant now/ is there a possibility that you may be pregnant? No Yes

9. Are you taking oral contraceptives, use an IUD or diaphragm or other implantable birth control?
If yes, describe: _____



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. *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 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.)

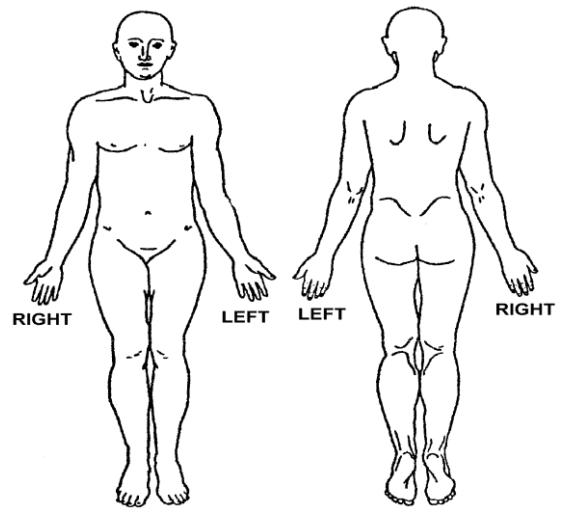
Have you had ANY prior surgery or operation (ex: arthroscopy, endoscopy, etc.)? No Yes

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

- Yes No Aneurysm clip(s)
- Yes No Cardiac Pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- 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

- | | | |
|------------------------------|-----------------------------|--|
| <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 pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial heart valve |
| <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 | Metal stent, filter, or coil |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aortic Graft |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intra ventricular) |
| <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 other implanted catheter |
| <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 metal 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 | Other implant; describe: _____ |

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



 **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 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