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? **If yes**, describe:	☐No	☐Yes
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 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 pf prosthesis (eye, penile, etc.)
☐ Yes ☐ No Medication patch (nicotine, nitroglycerine, etc.)

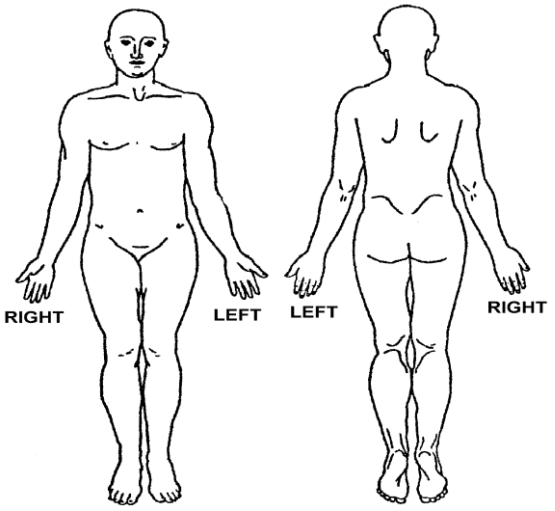
Have you had ANY prior surgery or operation (ex: arthroscopy, endoscopy, etc.)? ☐ No ☐ Yes

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

☐ 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 pump
☐ 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 Aortic Graft
☐ Yes ☐ No Shunt (spinal or intra ventricular)
☐ 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:_____

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**