

MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM FOR RESEARCH SUBJECTS

Date ____ / ____ / ____

Participant Number _____

Study Name or Principal Investigator _____

Name _____ Age _____ Height _____ Weight _____

Last name First name Middle initial

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 _____

Where was the surgery done? _____

2. Have you had a previous MRI examination or MR procedure? No Yes

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

If yes, please describe: _____

4. 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: _____

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

If yes, please describe: _____

6. Do you or have you ever had cancer? No Yes

If yes, please list when and what kind: _____

7. Have you had radiation or chemotherapy? No Yes

8. Do you have any allergies? No Yes

If yes, please list: _____

9. 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

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

If yes, please describe _____

11. Have you ever had a seizure? No Yes

12. Are you pregnant? I decline to answer this question and will not participate in the MRI No Yes

Information has been reviewed, and any and all changes since previous MR study are noted.

Date _____	Participant initials _____	Screener initials _____
Date _____	Participant initials _____	Screener initials _____
Date _____	Participant initials _____	Screener initials _____
Date _____	Participant initials _____	Screener initials _____



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, 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 Scanner Operator or Principal Investigator BEFORE entering the MR system room. **The MR system magnet is ALWAYS ON.**

Please indicate if you have any of the following implants and or devices:

<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	Ventricular Assist Device (VAD)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neuro, bone or bladder stimulator
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Deep Brain Stimulator (DBS)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Internal electrodes or wires
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eye Implant
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cochlear, otologic or other ear implant
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medication or other infusion pump
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Continuous Glucose Monitor (CGM)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any type of prosthesis (eye, penile, etc.)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mechanical heart valve
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Artificial or prosthetic limb
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metallic stent, shunt, filter, or coil
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medication patch
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any metallic fragment or foreign body:
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastric Capsule Camera

<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast tissue expander
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Surgical staples, clips, or metallic sutures
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Silver antimicrobial dressing
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you received Feraheme in past 4 weeks
<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 other pelvic devices
<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
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing aid (Remove before entering MR scanner room)
<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	High Blood Pressure
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Claustrophobia

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

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, cell phone, fitness devices, 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, and clothing with metallic threads.

Please consult the MRI Scanner Operator if you have any questions or concerns BEFORE you enter the MR

scanner room.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____ / ____ / ____
Signature

Form completed by:
 Participant Relative Nurse Other _____
 Print name Relationship to participant

Form Information Reviewed By: _____
 Print name Signature
 MRI Technologist Nurse Radiologist Other _____

Revised August-2021