

New York State Psychiatric Institute – MRI Research Program

MRI Safety Metal Screening Questionnaire

| SUBJECT ID (NO NAMES) | YEAR OF BIRTH | WEIGHT | DATE OF SCREENING |
|-----------------------|---------------|--------|-------------------|
| | | | |

The following items may make it **unsafe** for you to undergo MR imaging. Please indicate if you have any of the following by checking Yes or No:

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular access |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation seeds or implants |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Thermodilution catheter |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Electronic implant or device | <input type="checkbox"/> Yes <input type="checkbox"/> No Medication patch |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Magnetically-activated implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Shunt (spinal or intraventricular) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulation system | <input type="checkbox"/> Yes <input type="checkbox"/> No metallic fragment or foreign body |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal cord stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No Wire mesh implant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Internal electrodes or wires | <input type="checkbox"/> Yes <input type="checkbox"/> No Tissue expander (e.g., breast) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone growth/bone stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgical staples, clips, or sutures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear or other ear implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacement (hip, knee, etc) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or other infusion pump | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, wire, plate |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted drug infusion device | <input type="checkbox"/> Yes <input type="checkbox"/> No IUD, diaphragm, or pessary |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any type of prosthesis (eye, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures or partial plates |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoo or permanent makeup |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eyelid spring or wire | <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing jewelry |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial or prosthetic limb | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aid |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Metallic stent, filter, or coil | <input type="checkbox"/> Yes <input type="checkbox"/> No Other implant _____ |

Please verify if any of the following are applicable:

- Are you presently working, or have you ever worked as a machinist, metal worker, or in any profession grinding or using (e.g. artistically) metal? Yes No
- Any injury to the eye involving a metallic object or fragment (shrapnel, metal filings, etc.) Yes No
- Any bodily injury by a metallic object or foreign body (shrapnel, metal filings, bullet, etc.) Yes No
- Breathing problems or motion disorders Yes No
- Claustrophobia or discomfort in confined spaces Yes No
- Are you currently pregnant? If no, please provide date of LMP ___/___/___ N/A Yes No

IMPORTANT

Before entering the MR environment or MR system room, you must remove all metallic objects including: hearing aids, dentures, partial plates, keys, cell phones, eyeglasses, hair pins, barrettes, ALL jewelry, body piercings, watches, safety pins, paperclips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knives, nail clippers, tools, & clothing with metallic threads.

Subject has been screened with handheld metal detector Yes No

If Metal was detected, please indicate action taken: _____

If applicable, MRI compatible medical Implant clearance provided: N/A Yes No

By signing below, I attest that the above information is correct to the best of my knowledge. I have 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.

PARTICIPANT SIGNATURE _____ DATE ___/___/___

RESEARCH PERSONNEL _____ DATE ___/___/___

MRI TECHNOLOGIST _____ DATE ___/___/___