**MR Safety Screening Form**

for researchers or employees who need access to Zone III and IV

**Section I. Personal and study Information**

Name : UNI/Email:

Department: Supervisor:

Study Dates on IRB: Magnet:
Subject Category: Human/Non-Human/None If non-human, please specify:

List any controlled substances used in your study (if applicable):

**Section II. Researcher Health History and Condition**

Currently Pregnant: YES NO Claustrophobia: YES NO

Injury with Metal: YES NO Metal Fragment in Eyes: YES NO

Metal Worker: YES NO Surgery/Operation History: YES NO

Problem in a Previous MRI: YES NO Medications today or regularly: YES NO

Experience with MR contrast: YES NO Renal disease: YES NO Diabetes: YES NO

Respiratory disease: YES NO Hypertension: YES NO Seizure: YES NO Cardiovascular Disease: YES NO Hypotension: YES NO Fever: YES NO
Limited Thermoregulation: YES NO

If have other conditions, or answered yes to any of the above questions, please specify more details if requested by related MR personnel:

**Section III. Metals or Metal Powder**

Do you have any external object that contains metal or metal powder, including but not limited to hearing aid, colored contacts, jewelry, diaphragm for birth control, transdermal drug delivery patch (birth control, nicotine, nitro, fentanyl, etc), wig, clothing with metal threads or considered as anti-odor/anti-microbial/anti-bacterial, make-up, hair gel, glittery nail polish, powdered hair dye, toupee, hair extensions or weaves, underwire bra or bra with adjustable straps, removable bridgework, removable body piercings? YES  NO 

**All the above external objects may result in safety concern and should be removed.** If yes, please sign here after the external objects are removed: .

Do you have any internal or non-removable object that might contains metal or metal powder, including but not limited to the following items: braces on your teeth, permanent retainer, false teeth, tattoos, permanent make-up such as the eye-liner, non-removable body piercings? YES  NO  .

**Please be aware that all the above objects may result in safety concern**!
If yes, please specify or circle them

**Section IV. Implants**

Do you have any of the followings?

 Yes No Yes No Yes No

Cochlear implant ❑ ❑ Artificial heart valve ❑ ❑ Internal electrodes or wires ❑ ❑

Cardiac pacemaker, defibrillator ❑ ❑ Coil, stent, or filter ❑ ❑ Neuro-stimulator ❑ ❑

Implanted medication pump ❑ ❑ Medication Patch ❑ ❑ Eye injury from metal ❑ ❑

Aneurysm clip(s) ❑ ❑ Hearing aids ❑ ❑ False teeth or dentures ❑ ❑

Braces or retainers ❑ ❑ Eyelid spring or wire ❑ ❑ Tattoo or permanent makeup ❑ ❑

Joint replacement (hip, knee...) ❑ ❑ IUD, diaphragm or pessary ❑ ❑ Any prosthesis (eye, penile) ❑ ❑

Electronic implanted device ❑ ❑ Artificial or prosthetic limb ❑ ❑ Tissue expander (e.g. breast) ❑ ❑

Neurostimulation system ❑ ❑ Wire mesh implant ❑ ❑ Bone growth/fusion stimulator ❑ ❑

Spinal cord stimulator ❑ ❑ Implanted cardioverter (ICD) ❑ ❑ Any type of infusion pumps ❑ ❑

Body piercing jewelry ❑ ❑ Magnetically-activated device ❑ ❑ Any other implants or devices ❑ ❑

If YES, list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All Implants May Be Hazardous to Your Health in the Presence of Strong Magnetic Fields!**

**I understand that I must remove all electronic items, or any items that have magnetic properties, including but not limited to the following: phones, beepers, cameras, credit cards, magnetic strip cards, watches.**

**I will not bring any metal item into the MRI scan room during my scan, including but not limited to the following: keys, knife, coins, eyeglasses, safety pins, money/paper clips, mail clips, pens, hairpins/clips/, metal tools, chairs, carts, computers, fire-extinguishers, wheelchairs, and any other objects that might be attracted to the magnet.**

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

 **/ /**

Name of Researcher/Employee Signature of Researcher/Employee Date (mm/dd/yy)

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Name of Form Reviewer Signature of Form Reviewer Date (mm/dd/yy)