

MR PROCEDURE SCREENING FORM FOR RESEARCHERS OR EMPLOYEES

Name: _____ UNI/Email: _____

Supervisor: _____ Department: _____

Study Category: Human/ Non-Human/Other: _____ Magnet: _____

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

Please indicate the following:

Date of Birth (mm/dd/yy): ____/____/____ Height (feet' inches"): _____ Weight(lbs): _____

Mark the "yes" or "no" box for each question.

1. Have you experienced any problem related to a previous MRI examination or MR procedure? Yes No
2. Have you previously worked with metal or had an injury to the eye involving metallic objects or fragments (e.g. metallic silvers, shavings, foreign body, etc.)? Yes No
3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.) Yes No
4. Are you claustrophobic? Yes No
5. Are you pregnant, or do you think you may be pregnant? Yes No

Please indicate any medical conditions:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Limited Thermoregulation | <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension/Hypotension |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiovascular disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Renal disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Medications |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Surgeries/ Operations | <input type="checkbox"/> Yes <input type="checkbox"/> No Other |

If you have other conditions, or answered yes to any of the above, please specify more details:

The following items may be harmful to you in an MR setting or may interfere with image quality.

Please mark "yes" or "no" for every item as appropriate.

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacement (hip, knee, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/Joint pin, screw, nail, wire, plate |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> Yes <input type="checkbox"/> No Metallic stent, filter, or coil |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Electronic implant or device | <input type="checkbox"/> Yes <input type="checkbox"/> No Any type of prosthesis (eye, penile, etc) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Magnetically-activated device | <input type="checkbox"/> Yes <input type="checkbox"/> No Eye implant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulation system | <input type="checkbox"/> Yes <input type="checkbox"/> No Braces, dental implants, retainers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal cord stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No IUD or diaphragm |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Internal electrodes or wires | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoos or permanent make-up |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone growth/bone fusion stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No Pins/clips in hair, clothes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or other ear implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Removable retainers/dentures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or infusion pump/device | <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercings/ jewelry |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eyelid spring or wire | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aids |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Wire mesh implants | <input type="checkbox"/> Yes <input type="checkbox"/> No Wig/ Hair extensions |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial or prosthetic limb | <input type="checkbox"/> Yes <input type="checkbox"/> No Underwire bra/ Anti-fungal underwear |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Wire mesh implants, Patches | <input type="checkbox"/> Yes <input type="checkbox"/> No Colored contact lenses |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve prosthesis | |

If you have answered yes to any of the above, please specify more details by providing device information below:

ALL IMPLANTS MAY BE HAZARDOUS TO YOUR HEALTH IN 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, fitbits, cameras, credit cards, watches, magnetic strip cards, etc.

I will not bring in any metal item into the MRI scan room during my scan, including but not limited to the following: keys, knife, coins, eyeglasses, jewelry, piercings, safety pins, hair clips, money/paper clips, mail clips, pens, toupees/wigs/ weaves and any other metal apparel and any other objects that might be attracted to the magnet.

I understand I am required to wear earplugs and/or headphones during the MR scan.

I attest 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 about this form and ask questions regarding the MR procedure.

Signature of Research Participant

Date

MR SYSTEM USER ONLY:

1. MR System user reviewed the MR Safety Screening form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. MR System user discussed the potential MR side effects?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Subject removed all jewelry, piercings, etc?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Subject was verbally screened by MR user?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Subject was wanded using metal wand detector?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. MR System user asked subject if he/she has a pacemaker/implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name of MR system user

Signature of MR system user