MRI Screening Form

Please complete the MRI Screening Form below.

Thank you!

First Name: _____

Last Name: _____

Date of Birth: _____

Height: _____ (feet and inches)

Weight: _____ (pounds)

What is your dominant hand?
◯ Left hand
◯ Right hand

Do you wear prescription glasses?
◯ Yes
◯ No

If Yes, what is your glasses prescription? _____

Do you wear clear prescription contact lenses?
◯ Yes
◯ No

If Yes, would you be able to wear your prescription contact lenses on the day of the scan?
◯ Yes
◯ No

WARNING: MRI is generally very safe. However, certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, 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 Technologist or Investigator BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

1 Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind, particularly in the last six weeks?
◯ Yes
◯ No

If Yes, please indicate the date and type of surgery (list all, if more than one): _____

2	Have you ever experienced any problem related to a previous MRI examination or MR procedure?	◯ Yes ◯ No
	If Yes, please describe:	_____
3	Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic silvers, shavings, foreign body, etc.)?	◯ Yes ◯ No
	If Yes, please describe:	_____
4	Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?	◯ Yes ◯ No
	If Yes, please describe:	_____
5	Are you currently taking or have you recently taken any medication or drug?	◯ Yes ◯ No
	If Yes, please list:	_____
6	Do you have diabetes?	◯ Yes ◯ No
7	Do you have cardiac hypertension?	◯ Yes ◯ No
8	Do you take beta blockers?	◯ Yes ◯ No
9	Are you taking sedatives?	◯ Yes ◯ No
10	Do you take diuretics?	◯ Yes ◯ No
11	Do you have a fever?	◯ Yes ◯ No
12	FOR FEMALE SUBJECTS: Are you pregnant or experiencing a late menstrual period?	◯ Yes ◯ No ◯ N/A
13	FOR FEMALE SUBJECTS: Are you taking any type of fertility medication or having fertility treatments?	◯ Yes ◯ No ◯ N/A

14 Please indicate if you have any of the following:

- ☐ Aneurysm clip(s)
- ☐ Cardiac pacemaker
- ☐ Implanted cardioverter defibrillator (ICD)
- ☐ Electronic implant or device
- ☐ Magnetically-activated implant or device
- ☐ Neurostimulation system
- ☐ Spinal cord stimulator
- ☐ Internal electrodes or wires
- ☐ Bone growth/bone fusion stimulator
- ☐ Cochlear, otologic, or other ear implant
- ☐ Insulin or other infusion pump
- ☐ Implanted drug infusion device
- ☐ Any type of prosthesis (eye, penile, etc.)
- ☐ Heart valve prosthesis
- ☐ Eyelid spring or wire
- ☐ Artificial or prosthetic limb
- ☐ Metallic stent, filter, or coil
- ☐ Shunt (spinal or intraventricular)
- ☐ Top braces or retainers
- ☐ Vascular access port and/or catheter
- ☐ Radiation seeds or implants
- ☐ Swan-Ganz or thermodilution catheter
- ☐ Medication patch (Nicotine, Nitroglycerine)
- ☐ Any metallic fragment or foreign body
- ☐ Wire mesh implant
- ☐ Tissue expander (e.g. breast)
- ☐ Surgical staples, clips, or metallic sutures
- ☐ Joint replacement (hip, knee, etc.)
- ☐ Bone/joint pin, screw, nail, wire, plate, etc.
- ☐ IUD, diaphragm, or pessary
- ☐ Dentures or partial plates
- ☐ Tattoo or permanent makeup
- ☐ Body piercing jewelry
- ☐ Hearing aid
- ☐ Other implant
- ☐ Breathing problem or motion disorder
- ☐ Claustrophobia
- ☐ Weaves, hair implants, permanent wigs
- ☐ None of the above

If Yes to Tattoo or permanent makeup, what size is the tattoo and where is the tattoo located?

_____

If Yes to Tattoo or permanent makeup, what color is the ink?

_____

If Yes to Tattoo or permanent makeup, was the tattoo professionally obtained?

- ◯ Yes
- ◯ No

If Yes to Body piercing jewelry, can these be removed?

- ◯ Yes
- ◯ No

If Yes to Other implant, please describe:

_____

Notes:

(Notes for checkboxes above.)

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 cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Investigator if you have any question or concern BEFORE you enter the MR system room.

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.

Signature of Person Completing Form:

Date:

Form completed by:

- ◯ Subject
- ◯ Relative
- ◯ Other

If Other, print name and relationship to subject:

Form Information Reviewed By:

Name:

Signature:

Role:

- ☐ MRI Technologist
- ☐ Investigator
- ☐ Other

If Other, describe: