MAGNETIC RESONANCE (MR) SCREENING FORM FOR INDIVIDUALS

Note: *If Participant /Subject has completed this form for previous MR scanning session, indicate information has been reviewed by entering today's date and initials below*

Date ____/_____/___ Participant Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle initial

Date of Birth _____/_____/_____ Male □ Female □ Body part to be examined _____

Address _____ Telephone (home) (_____) _____-_____

City _____ Telephone (work) (_____) _____-_____

State _____ Zip code _____

Reason for MRI and/or symptoms _____

Referring physician _____ Telephone (_____)_____-_____

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 _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, ultrasound, etc.)? □ No □ Yes

If yes, please list:	Body part	Date	Facility
MRI	_____	_____/_____/_____	_____
CT/CAT scan	_____	_____/_____/_____	_____
X-ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
Other	_____	_____/_____/_____	_____

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. Are you currently taking or have you recently taken any medication or drug? □ No □ Yes
   If yes, please list: _____
7. Are you allergic to any medication? □ No □ Yes
   If yes, please list: _____
8. 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
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? If yes, please describe_____ □ No □ Yes

For female participants:

10. Date of last menstrual period: _____/_____/_____ Post menopausal? □ No □ Yes
11. Are you pregnant or experiencing a late menstrual period? □ No □ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? □ No □ Yes
13. Are you taking any type of fertility medication or having fertility treatments? □ No □ Yes
    If yes, please describe: _____
14. Are you currently breastfeeding? □ No □ Yes

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

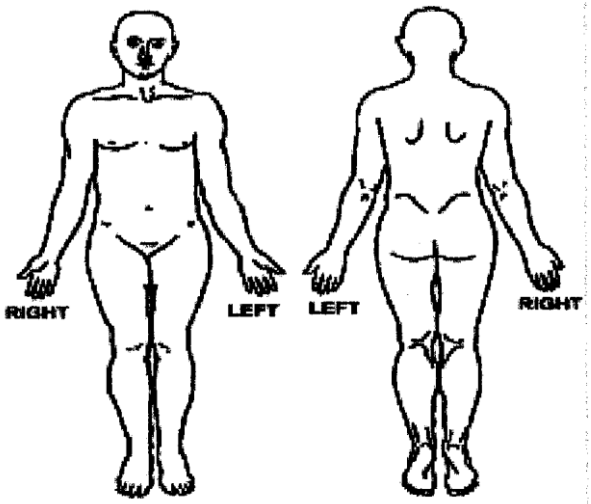
Date _____ Participant initials _____ Screener initials_____
Date _____ Participant initials _____ Screener initials_____
Date _____ Participant initials _____ Screener initials_____
Date _____ Participant initials _____ Screener initials_____
Date _____ Participant initials _____ Screener initials_____

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

Please indicate if you have any of the following:

☐ Yes ☐ No Aneurysm clip(s)
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Magnetically-activated implant or device
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Spinal cord stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth/bone fusion stimulator
☐ Yes ☐ No Cochlear, otologic, or other ear implant
☐ Yes ☐ No Insulin or other infusion pump
☐ Yes ☐ No Implanted drug infusion device
☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Artificial or prosthetic limb
☐ Yes ☐ No Metallic stent, filter, or coil
☐ Yes ☐ No Shunt (spinal or intraventricular)
☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Tissue expander (e.g., breast)
☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid
(*Remove before entering MR system room*)
☐ Yes ☐ No Other implant _____
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

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, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room.

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

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.

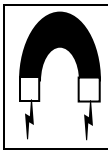
Signature of Person Completing Form: _____ Date_____/_____/_____
Signature

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

Form Information Reviewed By: _____ _____
Print name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other_____

MAGNETIC RESONANCE (MR) ENVIRONMENT SCREENING FORM FOR INDIVIDUALS



The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to fill out this form BEFORE entering the MR environment or MR system room. **Be advised the MR system magnet is ALWAYS on.**

*** NOTE: If you are a patient preparing to undergo an MR examination, you are required to fill out a different form.**

Date _____/_____/_____ Name _____ Age
Last name First name Middle initial

Address _____ Telephone (home) (_____) _____-_____

City _____ Telephone (work) (_____) _____-_____

State _____ Zip code _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes

   If yes, please indicate date and type of surgery: Date _____/_____/_____ Type of surgery _____
2. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? If yes, please describe: _____ ☐ No ☐ Yes
3. Have you ever been injured by a metallic object or foreign body (e.g., bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
4. Are you pregnant or suspect that you are pregnant? ☐ No ☐ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device or object.

IMPORTANT INSTRUCTIONS

Remove all metallic objects before entering the MR environment or MR system room including hearing aids, beepers, cell phones, eyeglasses, hair pins, barrettes, jewelry (including body piercing jewelry), watches, safety pins, paperclips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knives, nail clippers, steel-toed boots/shoes, and tools. Loose metallic objects are especially prohibited in the MR system room and MR environment.

Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room.

Please indicate if you have any of the following:

☐ Yes	☐ No	Aneurysm clip(s)
☐ Yes	☐ No	Cardiac pacemaker
☐ Yes	☐ No	Implanted cardioverter defibrillator (ICD)
☐ Yes	☐ No	Electronic implant or device
☐ Yes	☐ No	Magnetically-activated implant or device
☐ Yes	☐ No	Neurostimulation system
☐ Yes	☐ No	Spinal cord stimulator
☐ Yes	☐ No	Cochlear implant or implanted hearing aid
☐ Yes	☐ No	Insulin or other infusion pump
☐ Yes	☐ No	Implanted drug infusion device
☐ Yes	☐ No	Any type of prosthesis or implant
☐ Yes	☐ No	Artificial or prosthetic limb
☐ Yes	☐ No	Any metallic fragment or foreign body
☐ Yes	☐ No	Any external or internal metallic object
☐ Yes	☐ No	Hearing aid (*Remove before entering MR system room*)
☐ Yes	☐ No	Other implant _____

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

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

Form Information Reviewed By: _____ _____
Print name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other Date _____/_____/_____

Attention:
All Visitors To the Magnetic Resonance (MR) Area

Before you enter the Magnetic Resonance Environment

Do YOU have any of the following?

Cardiac Pacemaker?	NO	Yes, Do NOT Enter Magnet Room
Brain Aneurysm Clips?	NO	Yes, Do NOT Enter Magnet Room
Any electronic implants or devices?	NO	Yes, Do NOT Enter Magnet Room
Any potential metal in or near your eyes?	NO	Yes, Do NOT Enter Magnet Room
Any condition that may be adversely affected by strong magnetic fields? (large shrapnel, pregnancy?)	NO	Yes, Do NOT Enter Magnet Room
Anything in your pockets? (Coins, pocket knife, pens?)	NO	Yes, Do NOT Enter Magnet Room
Anything Ferro-magnetic or electronic on your person? (pager, cell phone, watch, jewelry?)	NO	Yes, Do NOT Enter Magnet Room

If all questions are answered “NO” you may enter room with your host

Use small basket to store your personal items while you are in the magnet area

Use hand held magnet to check items **BEFORE** taking them into the magnet area