MRI Safety Screening Form

Instructions: Please fill in or indicate Yes/No to each item below. Respond to each item individually. Items marked 'Yes' will be reviewed with the MRI technologist/operator. If uncertain of any answer, please circle and discuss with the MRI technologist/operator.

Date _____ Subject ID _____

Name (Last, First, Middle) _____

Sex (M, F, O) _____ Age _____ Date of Birth _____

Height _____ Weight _____

Section 1. General screening.

Yes ☐ No ☐ Do you have a cardiac pacemaker, defibrillator, or other cardiac implant (in place or removed)?

Yes ☐ No ☐ Do you have a cochlear, otologic, or hearing implant, or hearing aids?

Yes ☐ No ☐ Are you claustrophobic?

Yes ☐ No ☐ Have you had a joint replacement or do you have any artifical joints?

Yes ☐ No ☐ Have you had problems related to a prior MRI procedure?

If yes, describe: _____

Yes ☐ No ☐ Surgery or medical procedure of any kind?

If yes, describe: _____

_____

Current medications: _____

_____

All allergies: _____

Date of last menstrual period: _____

Yes ☐ No ☐ Is there a possibility that you are pregnant?

Yes ☐ No ☐ Are you post-menopausal?

Yes ☐ No ☐ Are you breastfeeding?

Section 2. Please indicate if you CURRENTLY HAVE or HAVE EVER HAD any of the following:

Yes ☐ No ☐ Injury by a metal object or foreign body (e.g. bullet, shrapnel).

If yes, describe: _____

Yes ☐ No ☐ Injury to your eye from a metal object.

If yes, did you seek medical assistance and what was the outcome? _____

_____

Yes ☐ No ☐ Foreign body removed from eye.

If yes, what was removed? _____

Yes ☐ No ☐ Asthma or other allergic respiratory disease.

Yes ☐ No ☐ Insulin or infusion pump.

Yes ☐ No ☐ Glucose monitoring device (Dexcom, freestyle Libre).

Yes ☐ No ☐ Kidney disease.

Yes ☐ No ☐ Hypertension.

Yes ☐ No ☐ Previously received contrast agent (dye) for a CT, MRI, X-ray, or study?

If yes, did you have an allergic reaction? _____

Yes ☐ No ☐ Spinal fusion procedure.

Yes ☐ No ☐ Endoscopy or colonoscopy in last three months (possible clips or markers)?

Section 3. Do you have any surgically IMPLANTED medical devices:

Yes ☐ No ☐ Any type of electronic, mechanical, or magnetic implant.

If yes, describe: _____

Yes ☐ No ☐ Cardiac pacemaker, defibrillator, or other cardiac implant (in place or removed).

Yes ☐ No ☐ Aneurysm clip.

If yes, describe: _____

Yes ☐ No ☐ Stimulator: neurostimulator, diaphragmatic, deep brain, vagus nerve, bone growth, spinal cord, or any biostimulator.

If yes, describe: _____

Yes ☐ No ☐ Any type of internal electrodes or wires.

Yes ☐ No ☐ Implanted drug pump (e.g. insulin, bacoflen, chemotherapy, pain medicine).

Yes ☐ No ☐ Spinal fixation device.

Yes ☐ No ☐ Any type of coil, filter, or stent.

If yes, describe: _____

Yes ☐ No ☐ Artificial heart valve.

Yes ☐ No ☐ Penile implant.

Yes ☐ No ☐ Artificial eye.

Yes ☐ No ☐ Eyelid spring and/or weight

Yes ☐ No ☐ Any type of implant held in place by a magnet.

Yes ☐ No ☐ Any type of surgical clip or staple.

Yes ☐ No ☐ Any IV access port (e.g. Broviac, Port-a-Cath, Hickman, PICC line).

Yes ☐ No ☐ Shunt.

If yes, describe: _____

Yes ☐ No ☐ Artificial limb.

If yes, describe: _____

Yes ☐ No ☐ Tissue expander (e.g. breast).

Yes ☐ No ☐ IUD, diaphragm, or pessary.

If yes, describe: _____

Yes ☐ No ☐ Surgical mesh.

If yes, describe: _____

Yes ☐ No ☐ Radiation seeds.

Yes ☐ No ☐ Any implanted items (e.g. pins, rods, screws, nails, plates, wires).

Section 4. Do you have any REMOVABLE medical devices:

Yes ☐ No ☐ Drug pump (e.g. insulin, Baclofen, Neulasta).

Yes ☐ No ☐ Medication patch (e.g. nitroglycerine, nicotine).

If yes, describe: _____

Yes ☐ No ☐ Dentures, false teeth, or partial plate.

Yes ☐ No ☐ Linx Reflux Management System (esophagus).

Yes ☐ No ☐ Have you recently ingested a pill cam, bravo or M2A?

If yes, describe: _____

Section 5. Do you have any of the following PERSONAL items:

Yes ☐ No ☐ Body piercings.

If yes, describe: _____

Yes ☐ No ☐ Wig, hair implants.

Yes ☐ No ☐ Tattoos or permanent makeup.

Yes ☐ No ☐ Hair accessories (e.g. bobby pins, barrettes, clips, extensions, weaves).

Yes ☐ No ☐ Jewelry.

Yes ☐ No ☐ Colored contact lenses.

Yes ☐ No ☐ Metal-containing clothing material and/or underwear (e.g. Lululemon, Copperfit, any silver/copper threaded).

Yes ☐ No ☐ Bra containing metallic underwire or clasps/adjusters.

Yes ☐ No ☐ Magnetic cosmetics and hair care (e.g. magnetic eyelashes, nail polish)

Yes ☐ No ☐ Electronic monitoring or tagging equipment (e.g. ankle monitor, tether, house arrest monitor).

Yes ☐ No ☐ Fitness tracker, biomonitor (e.g. Fitbit, Oura ring).

Yes ☐ No ☐ Any other type of surgically implanted medical devices, removable medical devices, or personal items not covered above?

If yes, describe: _____

Section 6. Instructions for MRI preparation.

1. Remove all jewelry (e.g. necklace, watch, rings).
2. Remove all hair pins, bobby pins, barrettes, clips, etc.
3. Remove all body piercings.
4. Remove dentures, false teeth, partial dental plates.
5. Remove eyeglasses and hearing aids.
6. Remove bras which contain metallic underwires or clasps/adjusters.
7. Change into provided scrubs if required.
8. Leave all personal items with your clothes (e.g. cell phones, credit cards).
9. If you are unable to remove any of the above items please notify the MRI technologist/operator.

Section 7. Review and Signatures.

I have read and understand the entire content of this form.

Participant Name (printed) _____

Participant Signature _____

Date _____

Reviewer 1.

Name (printed) _____

Signature _____

Date _____

Reviewer 2.

Name (printed) _____

Signature _____

Date _____