

Date: ___/___/20

Study #

MR RESEARCH FACILITY
MR Safety Screening Form

Subject Name _____ Study Title _____

Subject # _____ PI Name _____ PI phone (____) _____

Date of Birth ___/___/____ Height _____ [ft] Weight _____ [lb]

Sex ___ male ___ female Race ___ C ___ AA ___ H ___ A ___ Other (specify) _____

Physician _____ Telephone (____) _____ Fax (____) _____

Have you had prior surgery or an operation of any kind? No Yes

If yes, please indicate the date(s) and type(s) of surgery:

Have you had a prior MRI examination No Yes

If yes, please list: Date, Body part, Facility and Reason

Have you experienced any problem related to a previous MRI examination or MR procedure?

No Yes

If yes, please describe: _____

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: _____

Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?

No Yes

If yes, please describe: _____

Are you currently wearing any kind of clothing that contains metal thread? Your clothing labels are usually referred to as Silverescent Technology or anti-microbial? No Yes

Are you currently taking or have you recently taken any medication or drug? No Yes

If yes, please list: _____

Are you allergic to latex? No Yes
 Are you allergic to any medication? No Yes

If yes, please list: _____

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

If yes, please describe: _____

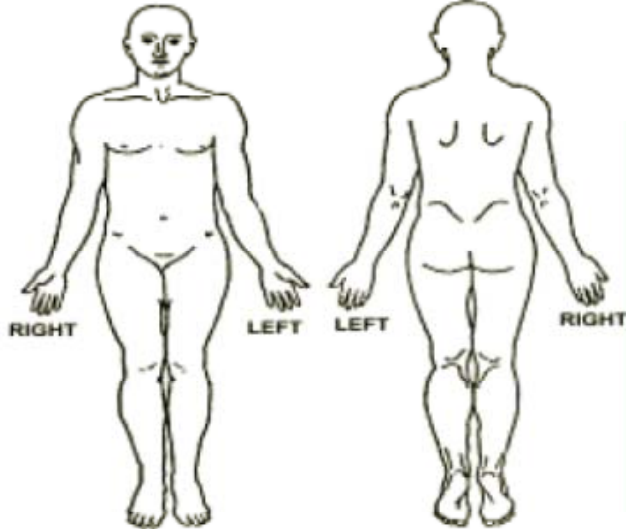
Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, diabetes, heart disease, migraines or seizures? No Yes

If yes, please describe: _____

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 Eye contact lens (circle or color)
 - 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 Braces
 - Yes No Body piercing jewelry
 - Yes No Hearing aid
- (Remove before entering MR system room)
- Yes No Other implant(s) _____
 - Yes No Breathing problem or motion disorder

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, & clothing with metallic threads.

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- Yes No Claustrophobia
- Yes No Difficulty lying flat

For female patients:

Post menopausal? No Yes

Date of last menstrual period: ___/___/___

Are you pregnant or experiencing a late menstrual period? No Yes

Are you taking oral contraceptives or receiving hormonal treatment? No Yes

Are you taking any type of fertility medication or having fertility treatments? No Yes

Are you currently breastfeeding? No Yes

Note: You will be required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards related to the loud noises the MRI scanner makes while taking pictures.

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 MRI procedure that I am about to undergo.

Signature person completing form: _____ Date ___/___/___

Form completed by: (print) _____ Time _____


Form reviewed by: _____ MRI technologist/operator Date ___/___/___

_____ RN or PI designate Date ___/___/___

*Serum creatinine test results: _____ mg/dl Date tested ___/___/___ NA
(All subjects receiving contrast must have this test on file with the MR Research facility before they will be scanned)

*Total contrast given _____ ml Contrast Type Magnevist Gadavist Lot# _____ NA

*Urine pregnancy test: Results: Pos___ Neg___ Date tested ___/___/___ NA
(All female subjects of childbearing age receiving contrast must be tested day of the MRI scan)

	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). <u>Do not enter</u> 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.
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