MR RESEARCH FACILITY
MR Safety Screening Form

Subject Name _______________________________    Study _______________________________

Subject # ______________________PI Name_______________________ PI phone_____________________

Height ________   Weight ________

Date of Birth _____/ _____/ _____   Sex ___ male ___female

Physician ___________________________________________   Telephone ( _____ ) _____ - ______________

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

MRI __________________________________________________________________________

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 taking or have you recently taken any medication or drug?  □ No □ Yes
If yes, please list: _____________________________________________________________________

Reference Frank G. Shellock Ph.D, www.MRIsafety.com
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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: ______________________________________________________

For female patients:

Date of last menstrual period: _____/ _____/ _____

Post menopausal? □ No □ Yes

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

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

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

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.
☐ 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
☐ Yes ☐ No  Difficulty lying flat

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) __________________________________ Date______________

Form reviewed by: __________________________________ MRI technologist/operator
______________________________________ RN or PI designate

*Serum creatinine test results: _____________ Date tested_____________
(All subjects receiving contrast must have this test on file with the MR Research facility before they will be scanned)

*Urine pregnancy test: Date tested __________ Results: Pos___ Neg___
(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 MRI procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or 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.

Reference Frank G. Shellock Ph.D, www.MRIsafety.com
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