**Date: __/__/20__**
**MM DD YYYY**

**Study #**

## MR RESEARCH FACILITY

***MR Safety Screening Form***

**Gadavist - _____ml**
**Start time:**
**End Time:**
**Time gap:**
**Start of T1 post:**

**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 ( ____ ) _____**

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**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: _____**

**Do you have any foreign object on your body (e.g., monitoring devices)?**

**□ 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**

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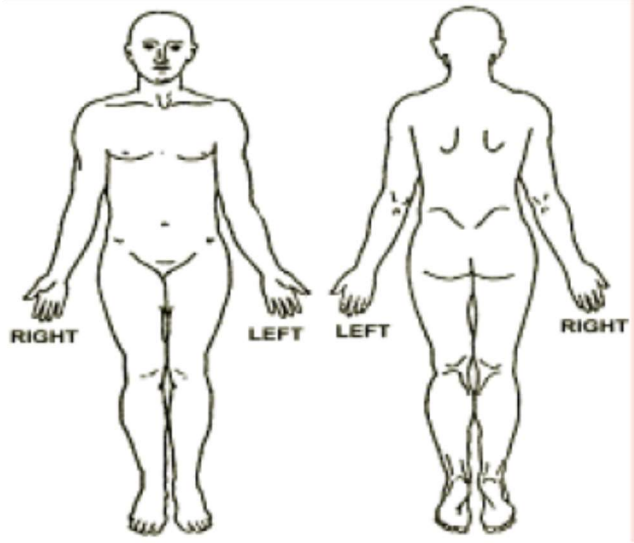
**Please indicate if you have any of the following:**

**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 <u>all</u> 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 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** (***Tattooed eye brows/eye liners, semi-permanent Eye lashes, permanent lip liner***)
**□ Yes □ No Tattooed eye brows/eye liners**
**□ Yes □ No Braces/Permanent Retainers**
**□ 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**
**□ Yes □ No Claustrophobia**
**□ Yes □ No Difficulty lying flat**

**□ None of the above**

**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**

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**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:***

***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.**

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**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____/____/_____**
**MM DD YYYY**

**Form completed by: (print) _____ Time_____**

**Form reviewed by: _____MRI technologist/operator Date____/____/_____**
**MM DD YYYY**

**_____ RN or PI designate Date____/____/_____**
**MM DD YYYY**

****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 □ 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)***

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**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.**

## NOTES