Center for Brain, Biology and Behavior

MRI Adolescent Safety Screening Form

For CB3 MRI Facility Technologist Use Only:

Date of MRI: _____ Appointment Time: _____ SKYRA ID: _____

Research Project Title: _____

Participant Name_____ **Date**_____

(Please print)

Date of Birth: _____ Height: _____ Weight: _____ □ Male □ Female

Some things make it dangerous for people to go in the MRI machine. Please answer the questions below honestly so we can make sure you are safe in the machine.

1. Please read the following list. If <u>any</u> of these things is true for you, mark the box underneath.

Have you ever had heart surgery?
Have you ever had brain surgery?
Have you ever had blood vessel surgery?
Could you be pregnant?

☐ **Mark this box if <u>any</u> of the things above are true.**

2. If <u>any</u> of these things is true for you, mark the box underneath.

Do you have an insulin or other infusion pump?
Do you have an implanted drug infusion devise?
Do you have a medication patch (Nicotine, Nitroglycerine, etc)
Do you have any metal fragment or foreign object in your body?
Do you have any shrapnel, gun shot or BB gun wounds?

☐ **Mark this box if <u>any</u> of the things above are true.**

3. If <u>any</u> of these things is true for you, mark the box underneath.

Have you ever worked with metal?
Have you ever had metal in your eyes?
Do you have breathing problems or motion disorder?
Do you have claustrophobia (fear of tight spaces) or PTSD?

☐ **Mark this box if <u>any</u> of the things above are true.**

4. There are a few more things we need to know. If you have <u>any</u> of these, mark the box underneath.

Dentures or partial plates, permanent retainer or braces
Tattoo or permanent make-up → *(May heat up during MRI scan)*
Body piercing or jewelry → *(Must be removed before entering)*
Hearing aid → *(Must be removed before entering)*
Colored contact lenses → *(Must be removed before entering)*
Hair extensions → *(May heat up during MRI scan)*

☐ **Mark this box if you have <u>any</u> of the things above.**

For Girls

Have you started your period? ☐ Yes ☐ No

If yes, what is the date of your last period? _____

Do you have an IUD, diaphragm, or pessary, or any implanted birth control? ☐Yes ☐ No

For Boys

Do you have any type of penis implant? ☐ Yes ☐ No

Participant Signature / Date _____

MRI Technologist Signature/ Date _____