

MRI 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

Please indicate if you have any of the following:

- Yes No Have you ever worked with metal?
- Yes No Have you ever had metal in your eyes?
- Yes No Breathing problems or motion disorder
- Yes No Claustrophobia or PTSD
- Yes No Any surgery in the last 6 weeks

The following items can interfere with MR imaging and some can be hazardous to your safety.

- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Aneurysm clip(s)
- Yes No Metallic embolization coils
- Yes No Metallic stent or filter for blood clots
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulator system or TENS unit or wires
- Yes No Spinal cord or brain stimulator
- Yes No Internal electrode or wires
- Yes No Bone growth stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion devise
- Yes No Heart valve prosthesis
- Yes No Any type of prosthesis or artificial device (eye, etc.)
- Yes No Artificial or prosthetic limb
- Yes No Eyelid spring or wire
- Yes No Shunt (spinal or brain-intraventricular)
- Yes No Vascular access port and/or catheter or feeding tube
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Radiation seeds or implants
- Yes No Medication patch (Nicotine, Nitroglycerine, etc)
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, metallic sutures
- Yes No Joint replacement (hip, knee, etc)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc
- Yes No Any metallic fragment or foreign body

- Yes No Any shrapnel, gun shot or BB gun wounds
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent make-up → *(May heat up during MRI scan)*
- Yes No Body piercing or jewelry → *(Must be removed before entering)*
- Yes No Hearing aid → *(Must be removed before entering)*
- Yes No Colored contact lenses → *(Must be removed before entering)*
- Yes No Hair extensions → *(May heat up during MRI scan)*

For Women

- Yes No Is there a possibility you may be pregnant?
Date of last period _____
- Yes No IUD, diaphragm, or pessary

For Men

- Yes No Any type of penile prosthesis or implant

Participant Signature/Date: _____

Parent or Legal Guardian Name: _____ **Relationship to Participant:** _____
(Please print)

Parent or Legal Guardian Signature/Date: _____

MRI Technologist Signature/Date: _____

Date of Return _____ No Changes Changes Indicated Above

Participant Signature/Date: _____

Parent or Legal Guardian Name: _____ Relationship to Participant: _____
(Please print)

Parent or Legal Guardian Signature/Date: _____

MRI Technologist Signature/Date: _____

Date of Return _____ No Changes Changes Indicated Above

Participant Signature/Date: _____

Parent or Legal Guardian Name: _____ Relationship to Participant: _____
(Please print)

Parent or Legal Guardian Signature/Date: _____

MRI Technologist Signature/Date: _____

Date of Return _____ No Changes Changes Indicated Above

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Parent or Legal Guardian Name: _____ Relationship to Participant: _____
(Please print)

Parent or Legal Guardian Signature/Date: _____

MRI Technologist Signature/Date: _____