MAGNETIC RESONANCE (MR) SCREENING FORM FOR INDIVIDUALS

Note: If Participant/Subject has completed this form for previous MR scanning session, indicate information has been mimed by entering today date and initials below.

Date ____/_____/_____ Participant Number _____

Name _____ Age _____ Height _____ Weight _____

Date of Birth _____ Male ☐ Female ☐ Body part to be examined _____

Address _____ Telephone (home) (_____) _____ - _____

City _____ Telephone (home) (_____) _____ - _____

State _____ Zip Code _____

Reason for MRI and/or symptoms _____

Referring physician _____ Telephone (_____) _____ - _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery: Date ____/____/____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, ultrasound, etc.)? ☐ No ☐ Yes
   If yes, please list: Body part Date Facility
   MRI _____ ____/____/____ _____
   CT/CAT scan _____ ____/____/____ _____
   X-ray _____ ____/____/____ _____
   Ultrasound _____ ____/____/____ _____
   Nuclear Medicine _____ ____/____/____ _____
   Other _____ ____/____/____ _____
3. Have you experienced any problem related to a previous MRI examination or MR procedure ☐ No ☐ Yes
   If yes, please describe: _____
4. 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: _____
5. Have you ever been injured by a metallic object or foreign body (BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
   If yes, please list: _____
7. Are you allergic to any medication? ☐ No ☐ Yes
   If yes, please list: _____
8. 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
9. Do you have anemia or any disease (s) that affects your blood, a history of renal (kidney) disease, or seizures? If yes, please describe _____ ☐ No ☐ Yes

For female participants:

10. Date of last menstrual period: ____/____/_____ Post menopausal? ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
    If yes, please describe: _____
14. Are you currently breast-feeding? ☐ No ☐ Yes

Information has been reviewed, and any and all changes since previous MR study are noted.

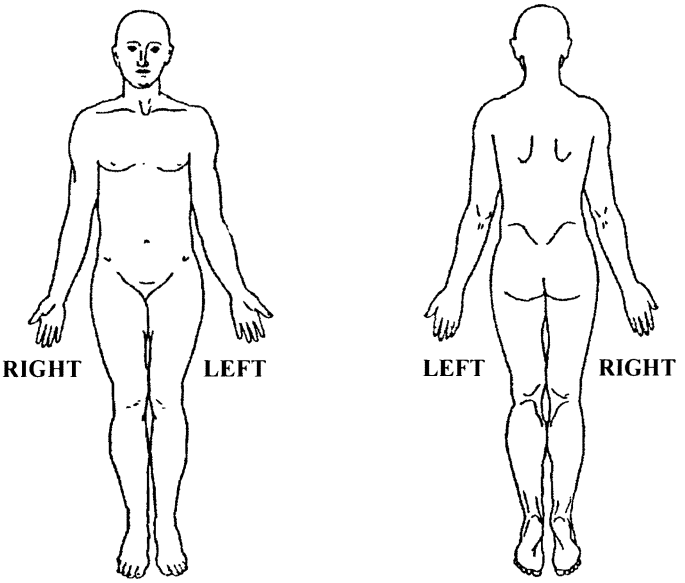
Date _____	Participant initials _____	Screener initials _____
Date _____	Participant initials _____	Screener initials _____
Date _____	Participant initials _____	Screener initials _____
Date _____	Participant initials _____	Screener initials _____
Date _____	Participant initials _____	Screener initials _____

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.

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
☐ 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

Please mark on the figure(s) below the location of any implant or metal inside of you 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, paper clips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protecting during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form completed by ☐ Participant ☐ Relative ☐ Nurse _____ _____
Print name Relationship to participant

Form Information Reviewed By: _____ _____
Print name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other _____