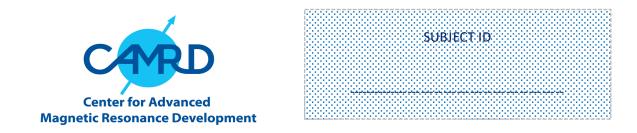
## **MRI Screening Form for Research Subjects and Personnel**



You have been scheduled for an MRI exam. The MRI scanner uses extremely strong magnetic fields that can produce heating, movement or electric currents in ANY metal in or on your body. WARNING: This can be hazardous to you if you have certain metal objects in or on you. Please complete this form accurately and carefully. Section 1: Please mark ALL that may apply: (If patient is unable to give accurate answers please see section 4) Have you had surgeries to the: BRAIN HEART SPINE

Please list ALL Surgeries:							
Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel)?						No	
Have you had an injury to the eye in	nvolving a metal object	or fragment (grinding or	welding)?	Yes		No	
have you had surgenes to the.							

For WOMEN: Date of last menstrual period? Section 2: Please mark ALL that may apply

Pacemaker / defibrillator (ICD)	Yes	No		Heart valve prosthesis	Yes	No	
Aneurysm clip(s) / aneurysm repair	Yes	No		Prosthetic limb	Yes	No	
Breast tissue expander	Yes	No		Vascular stent, filter, coil	Yes	No	
Drug infusion device or pump	Yes	No		Programmable shunt	Yes	No	
Vagus Nerve Stimulator (VNS)	Yes	No		Prosthesis (penile, eye etc.)	Yes	No	
Stimulator/implanted electrical device	Yes	No		Cochlear, ear, or inner ear surgery	Yes	No	
Internal electrodes or wires	Yes	No		Eyelid implant, eye surgery	Yes	No	
Tracheostomy	Yes	No		Body jewelry, piercings and/or tattoo(s)	Yes	No	
Medication patch	Yes	No		Hx of Gunshot or Shrapnel wound	Yes	No	
Epidural/Swan-Ganz catheter	Yes	No		Metal rods, screws, pins etc.	Yes	No	
IUD or pessary	Yes	No		Joint replacement (knee, hip, etc.)	Yes	No	
Recent endoscopy	Yes	No		Dentures / partial plates	Yes	No	
Have you had a prior MRI?	Yes	No		Hearing aid (remove before entering room)	Yes	No	
If yes, where?		 	-	Claustrophobia	Yes	No	

## Section 3: (Must be completed by patient or person reviewing form with patient)

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.						
Form completed by (Circle One): Patient / Relative / RN / MD	Signature:					
Print Name:	Date:// Time::					

## Section 5: (MRI Staff Use Only)

Reviewed by:		/	//	:
	MRI Technologist Signature	MRI Technologist Printed Name	Date	Time