MRI Screening Form for Research Subjects and Personnel

Center for Advanced
Magnetic Resonance Development

SUBJECT ID

_____

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 ☐

Have you had an **injury to the eye** involving a metal object or fragment (grinding or welding)? Yes ☐ No ☐

Have you ever been **injured by a metallic object or foreign body** (e.g. BB, bullet, shrapnel)? Yes ☐ No ☐

Please list ALL Surgeries: _____

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**