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
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Information</th>
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<tbody>
<tr>
<td>Any shrapnel, gun shot or BB gun wounds</td>
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<td>Dentures or partial plates</td>
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<td>Tattoo or permanent make-up → <em>(May heat up during MRI scan)</em></td>
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<td>Body piercing or jewelry → <em>(Must be removed before entering)</em></td>
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<td>Hearing aid → <em>(Must be removed before entering)</em></td>
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<td>Colored contact lenses → <em>(Must be removed before entering)</em></td>
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<td>Hair extensions → <em>(May heat up during MRI scan)</em></td>
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<td><em>For Women</em></td>
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<td>Is there a possibility you may be pregnant?</td>
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<td>Date of last period</td>
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<td>IUD, diaphragm, or pessary</td>
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<td><em>For Men</em></td>
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<td>Any type of penile prosthesis or implant</td>
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**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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*(Please print)*

Parent or Legal Guardian Signature/Date: ______________________

MRI Technologist Signature/Date: ______________________

Date of Return: ______________________ __ No Changes  __ Changes Indicated Above

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*(Please print)*

Parent or Legal Guardian Signature/Date: ______________________

MRI Technologist Signature/Date: ______________________