**MAGNETIC RESONANCE (MR) SAFETY SCREENING FORM**

**Please complete both sides in their entirety**

*(If under 18, form must be signed and completed by parent or legal guardian)*

<table>
<thead>
<tr>
<th>Date</th>
<th>Male</th>
<th>Female</th>
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**Subject ID ____________________________ Age ________ Height ________ Weight ________**

1. Have you had prior surgery or an operation (e.g., heart, brain, spine, eyes, abdominal) of any kind?  
   **No** **Yes**
   
   If yes, please indicate the date and type of surgery:  
   
   Date _____/_____/_____ Type of surgery ________________________________
   Date _____/_____/_____ Type of surgery ________________________________
   Date _____/_____/_____ Type of surgery ________________________________
   Date _____/_____/_____ Type of surgery ________________________________

2. Is this your first MRI?  
   **No** **Yes**

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 (e.g., BB, bullet, shrapnel, etc.)?  
   **No** **Yes**
   
   If yes, please describe: ________________________________________________

6. Have you had surgery in the last 8 weeks?  
   **No** **Yes**
   
   If yes, please list: _____________________________________________________

7. Are you wearing a wig or have any other artificial hair?  
   **No** **Yes**

8. Can you stand without assistance?  
   **No** **Yes**

9. Are you wearing clothing that contains metallic fibers? (Anti-odor or microbial, copper brace, etc)  
   **No** **Yes**

10. Do you require vision correction?  
    **No** **Yes**
    
    If yes, please wear contacts or bring your prescription information

11. Do you have any dental work other than fillings? (Please indicate if removable)  
    **No** **Yes**
    
    If yes, please list: _____________________________________________________

For female participants:

12. Are you pregnant or think you may be pregnant?  
    **No** **Yes**

13. Are you wearing a bra with a metal underwire, clasps, or adjusters?  
    **No** **Yes**
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  Small bowel endoscopy capsule
- Yes  No  Swan-Ganz or thermodilution catheter
- Yes  No  Medication patch
- 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 (circle which)
- Yes  No  Dental braces
- 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 or on your body.

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**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, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Director if you have any question or concern BEFORE you enter the MR system room.

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**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 Director BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

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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 _____/_____/_____

Form Completed By:  Participant   Relative   RA ___________________________ ___________________________

Form Information Reviewed By: ___________________________ Signature