



This MR system has a very strong static field that may be hazardous to individuals entering the magnet room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form BEFORE entering the magnet room. Be advised, the magnet is ALWAYS ON.

1. Have you had prior surgery or an operation (eg. athroscopy, endoscopy, etc) of any kind? ☐ Yes ☒ No
If yes, please provide Date: _____ Type of Surgery: _____
2. Have you had an injury to the eye involving a metallic object (e.g. metallic slivers, foreign body)? ☐ Yes ☒ No
If yes, please describe: _____
3. Have you ever been injured by a metallic object (e.g. BB, bullet, shrapnel, welding accident, etc.)? ☐ Yes ☒ No
If yes, please describe: _____
4. Are you pregnant or suspect that you are pregnant? ☐ Yes ☒ No
5. Have you had a previous contrast agent reaction? ☐ Yes ☒ No



WARNING: Certain implants, devices or objects may be hazardous to you in the MR environment or the magnet room. **DO NOT ENTER** the MR environment or the magnet room if you have any of the following implants, devices or objects.

IMPORTANT: Remove all metallic objects before entering the MR environment or magnet room. Loose metallic objects are especially prohibited.

Please indicate if you have the following:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Aneurysm clip(s) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Dentures or partial plates (remove) |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Cardiac pacemaker, pacemaker wires, or stents | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Hearing aid (remove) |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Metal object (ie keys, coins—must remove) |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Electronic or magnetically-activated implant or device (electrodes, wires, metallic filter or coil) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Other implant(s) _____ |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Neurostimulation system, spinal cord stimulator | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Breathing problem or motion disorder |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Implanted or transcutaneous bio-stimulator(spinal cord, bone growth/bone fusion, tens unit, etc.) | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Do you have claustrophobia? |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Insulin or other infusion pump | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Implanted drug infusion device | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Any type of prosthesis (heart valve, eyelid spring/wire, penile, limb, etc.) | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Shunt (spinal or intraventricular) | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Vascular access point and/or catheter | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Radiation seeds or implants | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Swan/Ganz or thermodilution catheter | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Medication patch (ie. nicotine, nitroglycerine) | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Wire mesh implant | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Surgical staples, clips or metallic sutures | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Joint replacement (hip, knee, etc.) | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate, etc. | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tissue expander (e.g. breast) | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IUD, diaphragm, or pessary | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Tattoo or permanent cosmetics | |
| <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Body piercing jewelry | |

Internal Use Only

Field Strength: 3T ☐ 7T ☐
MRI Technologist Comments:

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

MRI Research Participant:

Aaron Stenke
Print Name

[Signature]
Signature

Date: 09/21/17

MRI Technologist:

Print Name

Signature

Date: _____