Protocol: Pro00090492_ Exam Number: _____ Date:_____

Duke-UNC Brain Imaging and Analysis Center: MRI Safety Screening

All individuals entering the MRI suite must fill out this information to the best of their knowledge. Any potential contraindications must be reviewed with the individual's medical record and the BIAC MR Safety Committee before being cleared to enter the scanner bore.

Part I: For all individuals entering the scanner room

Name _____ Birthdate _____
Last name First name M.I.

Address _____ City _____

State_____ Zip Code _____ Phone (H)(_____) _____ (W)(_____) _____ (C)(_____) _____

1. Have you ever had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, foreign body)? ☐ No ☐ Yes
   If yes, please describe:_____
2. Have you ever worked with metal (grinding, fabricating, etc.)? ☐ No ☐ Yes
   If yes, please describe:_____
3. Have you ever had surgery (including eye surgery)? ☐ No ☐ Yes
   If yes, please describe:_____
4. Have you had any previous MRI studies or been in a MR scanner? ☐ No ☐ Yes
   If yes, please list (most recent first): Body part _____ Date_____ Facility_____
   If yes, did you have any problems? _____

Before you may enter the scanner room, you must remove all metallic objects.

- ☐ All contents of pockets, including back pockets
- ☐ Wrist watch, any bracelets
- ☐ Hair pins, clips, weaves, fasteners
- ☐ Pins or badges on shirt
- ☐ Belt with metal (e.g., buckle)
- ☐ Shoes that contain any metal (e.g., steel tipped)
- ☐ Hearing aids or other electronic devices
- ☐ Pagers, cell phones, PDAs
- ☐ Dentures or removable retainer
- ☐ Necklaces, chains

Part II: For all individuals entering the scanner bore

1. Are you claustrophobic? ☐ No ☐ Yes
2. Do you have an IUD or diaphragm containing metal? ☐ No ☐ Yes
3. Are you pregnant, experiencing late menstrual period, or undergoing fertility treatment? ☐ No ☐ Yes
4. Do you currently have a fever or other acute illness? ☐ No ☐ Yes
5. Please list any surgeries or other invasive medical procedures in **as much detail as possible**:

_____

_____

_____

6. Are you currently taking or have you recently taken any medication? ☐ No ☐ Yes

If yes, please list _____

7. Do you have anemia or any diseases that affect your blood? ☐ No ☐ Yes

If yes, please describe _____

8. Do you have a history of stroke, seizures, brain tumor, head trauma, or other neurological disorder? ☐ No ☐ Yes

If yes, please describe _____

9. Do you wear glasses or contact lenses? ☐ No ☐ Yes

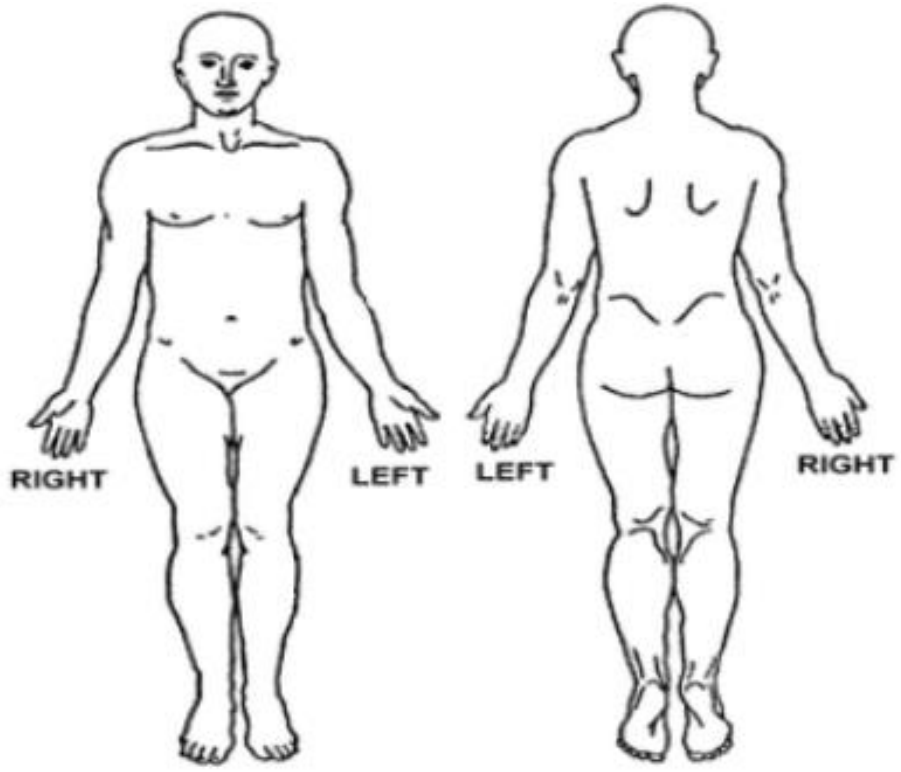
If yes, please specify prescription (if known) _____

10. Do you have a breathing disorder (e.g., asthma, apnea), heart condition, or movement disorder? ☐ No ☐ Yes

Height _____ Weight _____ Handedness _____

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 questions or concerns regarding an implant, device, or on object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR magnet is ALWAYS on.

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



Protocol: Pro00090492_____ Exam Number: _____ Date:_____

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 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	Radiation seeds or implants
☐ Yes	☐ No	Medication patch (Nicotine, Nitroglycerine)
☐ Yes	☐ No	Any metallic fragment or foreign body
☐ Yes	☐ No	Wire mesh implant
☐ Yes	☐ No	Tissue expander (i.e. 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	Dentures or partial plates
☐ Yes	☐ No	Tattoo or permanent makeup
☐ Yes	☐ No	Body piercing or jewelry
☐ Yes	☐ No	Hearing aid (**remove before entering MRI**)
☐ Yes	☐ No	Other implant_____

If needed, please use this space to describe in detail any additional information related to potential metal fragments or implants in or on your body:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

⚠ IMPORTANT INSTRUCTIONS ⚠

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, cell phone, eyeglasses, beeper, 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, and clothing with metallic threads. You will be asked to wear ear plugs to protect your hearing during the scan.

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

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 | Signature of Person Screening Subject/Patient | Date

Form Completed by: ☐ Self ☐ Parent/guardian ☐ Other relative ☐ Physician