NMR CENTER MRI SAFETY SCREENING QUESTIONNAIRE

Required Identification Information:

Name: _____ Date of exam _____
Patient number _____ Date of birth _____
Sex: Male _____ Female_____ Age ___ Height _____Weight _____
Principal Investigator_____ Protocol number _____

Remove all metallic objects including, electronics **(cell phones)**, keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, hearing aids, partial dental plates, coins, pens, belt, body piercing (removable), anti-odor/microbial active wear etc. **before entering the MRI magnet room (Zone 4).**

Please circle each response:

1. Did you (your legal guardian) grant informed consent to participate in the MR study? ……. yes no
2. Have you had any previous MRI studies at NIH? ……. yes no
3. Have you had an eye injury involving a metallic object (e.g., metal slivers, foreign body)? yes no
   If yes, please describe: _____
4. Have you been injured by a metallic object (e.g. BBs, bullets, shrapnel etc) …… yes no
   If yes, please describe: _____
5. Have you had any surgeries or any similar invasive procedures? ……. yes no
   If yes, list all prior surgeries and approximate dates on the back of this form.
6. Women: Are you, or might you be, pregnant? ……. yes no
7. Women: Are you currently breast feeding? ……. yes no
8. Do you have a history of kidney disease, seizure, diabetes, or any blood diseases (Anemia or Sickle Cell)?..... yes no
9. Do you have any drug or latex allergies? If yes, list allergies on the back of this form. yes no
10. List your medications: (Use back if necessary) _____
11. Have you ever had a reaction to a contrast medium used for MRI or CT? …… yes no
12. Do you have claustrophobia (fear of closed places)? …… yes no
13. Do you have any known hearing problems? e.g. ringing, sensitive to loud noise, yes no

Do you have any of the following (please circle each response):

Cardiac pacemaker ……	yes no	Any type of prosthesis (eye,penile)	yes no
Implanted cardiac defibrillator……	yes no	Heart valve prosthesis ……	yes no
Aneurysm clip ……	yes no	Shunt (spinal/intraventricular)…	yes no
Neuro or Bone Stimulator ……	yes no	Wire sutures or surgical staples….	yes no
Insulin or infusion Pump ……	yes no	Bone/joint pin, screw, nail, plate.	yes no
Implanted drug infusion device ……	yes no	Body/makeup (eyeliner/lip) tattoos	yes no
Cochlear, otologic, or ear implant ..	yes no	Body piercing(s) (non-removable) ….	yes no
Prostate radiation seeds ……	yes no	Breast tissue expander ……	yes no
IUD (intrauterine device) ……	yes no	Other metallic implants/objects …..	yes no
Transdermal medication patch (Nitro)	yes no		

Patient/Legal guardian signature _____ Date_____

If MRI contraindications are present, the physician or the nurse practitioner responsible for the MRI must approve the scan. Supporting documentation (e.g. operative reports) must be available at the time of the scan. Enter any other screening notes on the back of this form.

MD/NP name & signature _____ Date _____

Is a ferromagnetic detector available? Yes / No Result: Pass (green) / Fail (red)

Technologist/Investigator name & signature_____ Date _____

Revised 12/03/2018