Appendix 4: Metal Screening Form

UCSB BRAIN IMAGING CENTER MAGNET SCREENING FORM

Date _____/_____/_____ Subject ID:

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ☐ Female ☐
month day year

Address _____

City _____

State _____ Zip Code _____

Telephone (home) (_____) _____-_____

Email Address _____

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ White
☐ American Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian or Other Pacific Islander
☐ Black or African American
☐ More Than One Race
☐ Unknown or Not Reported

1. Have you ever had surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
If yes, please indicate date and type of surgery:

2. Have you had a prior diagnostic imaging study or examination with 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 done any welding, grinding or cutting of metal in your lifetime? ☐ No ☐ Yes

6. Did you wear safety protection for your eyes? ☐ No ☐ Yes

7. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

For Female Volunteers:

8. Are you currently pregnant or is there any possibility that you may be pregnant (e.g., late menstrual period)? ☐ No ☐ Yes

MAGNETIC SCREENING FORM PAGE 2

If you have any question regarding an implant, device, or possible metal object, please discuss this with the MRI Technologist or Researcher BEFORE entering the MRI room.

Please indicate if you have any of the following:

□ Yes □ No Dentures or partial plates

□ Yes □ No Head or Neck Tattoo or Permanent Makeup

□ Yes □ No Body piercing jewelry

□ Yes □ No IUD or diaphragm

□ Yes □ No Electronic implant or device

If yes, which of the following apply:
Magnetically-activated implant or device
Cardiac pacemaker Implanted cardioverter defibrillator (ICD)
Aneurysm clip(s)
Neurostimulation system
Spinal cord stimulator
Internal electrodes or wires
Bone growth/bone fusion stimulator
Cochlear, otologic, or other ear implant
Insulin or infusion pump
Implanted drug infusion device
Any type of prosthesis (eye, penile, etc.)
Heart valve prosthesis
Eyelid spring or wire
Artificial or prosthetic limb
Metallic stent, filter, or coil
Shunt (spinal or intraventricular)
Vascular access port and/or catheter
Wire mesh implant
Surgical staples, clips, or metallic sutures
Joint replacement (hip, knee, etc.)
Bone/joint pin, screw, nail, wire, plate, etc.
Radiation seeds or implants

□ Yes □ No Medication patch (Nicotine,Nitroglycerine)

□ Yes □ No Any metallic fragment or foreign body

□ Yes □ No Any transdermal patch

□ Yes □ No Hearing aid **(Remove before entering MR system room**)

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 and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form _____ Date____/_____/____
Signature

Form Completed By _____ _____
Print name Relationship to person entering magnet room

Form Information Reviewed _____ _____
Print name Signature