

### MRI Safety Screening Form

**For CB3 MRI Facility Technologist Use Only:**

Date of MRI: \_\_\_\_\_ Appointment Time: \_\_\_\_\_ SKYRA ID: \_\_\_\_\_

Research Project Title: \_\_\_\_\_

**Participant Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*(Please print)*

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  Male  Female

**Please indicate if you have any of the following:**

- Yes  No Have you ever worked with metal?
- Yes  No Have you ever had metal in your eyes?
- Yes  No Breathing problems or motion disorder
- Yes  No Claustrophobia or PTSD
- Yes  No Any surgery in the last 6 weeks

**The following items can interfere with MR imaging and some can be hazardous to your safety.**

- Yes  No Cardiac pacemaker
- Yes  No Implanted cardioverter defibrillator (ICD)
- Yes  No Aneurysm clip(s)
- Yes  No Metallic embolization coils
- Yes  No Metallic stent or filter for blood clots
- Yes  No Electronic implant or device
- Yes  No Magnetically-activated implant or device
- Yes  No Neurostimulator system or TENS unit or wires
- Yes  No Spinal cord or brain stimulator
- Yes  No Internal electrode or wires
- Yes  No Bone growth stimulator
- Yes  No Cochlear, otologic, or other ear implant
- Yes  No Insulin or other infusion pump
- Yes  No Implanted drug infusion devise
- Yes  No Heart valve prosthesis
- Yes  No Any type of prosthesis or artificial device (eye, etc.)
- Yes  No Artificial or prosthetic limb
- Yes  No Eyelid spring or wire
- Yes  No Shunt (spinal or brain-intraventricular)
- Yes  No Vascular access port and/or catheter or feeding tube
- Yes  No Swan-Ganz or thermodilution catheter
- Yes  No Radiation seeds or implants
- Yes  No Medication patch (Nicotine, Nitroglycerine, etc)
- Yes  No Wire mesh implant
- Yes  No Tissue expander (e.g., breast)
- Yes  No Surgical staples, clips, metallic sutures
- Yes  No Joint replacement (hip, knee, etc)
- Yes  No Bone/joint pin, screw, nail, wire, plate, etc
- Yes  No Any metallic fragment or foreign body

- Yes     No    Any shrapnel, gun shot or BB gun wounds
- Yes     No    Dentures, partial plates, permanent retainer or braces
- Yes     No    Tattoo or permanent make-up → *(May heat up during MRI scan)*
- Yes     No    Body piercing or jewelry → *(Must be removed before entering)*
- Yes     No    Hearing aid → *(Must be removed before entering)*
- Yes     No    Colored contact lenses → *(Must be removed before entering)*
- Yes     No    Hair extensions → *(May heat up during MRI scan)*
- Yes     No    Other \_\_\_\_\_

**For Women**

- Yes     No    Is there a possibility you may be pregnant?  
Date of last period \_\_\_\_\_
- Yes     No    IUD, diaphragm, or pessary

**For Men**

- Yes     No    Any type of penile prosthesis or implant

**Participant Signature/Date:** \_\_\_\_\_

**Parent or Legal Guardian Name:** \_\_\_\_\_ **Relationship to Participant:** \_\_\_\_\_  
*(Please print)*

**Parent or Legal Guardian Signature/Date:** \_\_\_\_\_

**MRI Technologist Signature/Date:** \_\_\_\_\_

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**Date of Return** \_\_\_\_\_  No Changes                       Changes Indicated Above

Participant Signature/Date: \_\_\_\_\_

Parent or Legal Guardian Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
*(Please print)*

Parent or Legal Guardian Signature/Date: \_\_\_\_\_

MRI Technologist Signature/Date: \_\_\_\_\_

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**Date of Return** \_\_\_\_\_  No Changes                       Changes Indicated Above

Participant Signature/Date: \_\_\_\_\_

Parent or Legal Guardian Name: \_\_\_\_\_ Relationship to Participant: \_\_\_\_\_  
*(Please print)*

Parent or Legal Guardian Signature/Date: \_\_\_\_\_

MRI Technologist Signature/Date: \_\_\_\_\_

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**Date of Return** \_\_\_\_\_  No Changes                       Changes Indicated Above

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*(Please print)*

Parent or Legal Guardian Signature/Date: \_\_\_\_\_

MRI Technologist Signature/Date: \_\_\_\_\_