

MRI SAFETY SCREENING FORM

| VOLUNTEER INFORMATION | | | |
|-----------------------|----------------|---------|---------|
| NAME: | DATE OF BIRTH: | HEIGHT: | WEIGHT: |



WARNING: Certain implants, devices, objects, and attire may be hazardous to you and/or may interfere with the MRI procedure. **Do NOT** enter the MRI system room if you have **ANY metal** in or on your body, or MR environment if you have any question or concern regarding any implant, device, or object. **Consult** the MRI staff **BEFORE** entering the MRI system room. **The MRI system magnet is ALWAYS on.**

Please circle yes or no for each of the following questions:

| | |
|---|---|
| Do you or have you ever had a pacemaker, wires, cardiac defibrillator or implanted loop recorder? Yes No | Are you claustrophobic? Yes No |
| Have you ever been hit in the face or eye with a piece of metal, or had a piece of metal removed from your eye? (including metal shavings, slivers, bullets, or BB's) Yes No | Do you have any history of cancer or demyelinating disease? Yes No |
| Have you ever been injured by any metal shrapnel or a gunshot? Yes No | Are you wearing any piercings (must remove), hearing aids (must remove), or color contact lens (may need to remove)? Yes No |
| Do you have or have you ever had any aneurysm clips or coils? Yes No | Do you have any body, eyelid, or other permanent tattoos? Yes No |
| Do you have or have you ever had an implanted electrical stimulator or infusion pump? (e.g., deep brain stimulator, vagal nerve stimulator, implanted medication pump, implanted bone or nerve stimulator) Yes No | Do you have any dentures, braces, or permanent retainer? (Dentures or partials may need to be removed) Yes No |
| Do you have or have you ever had a stent, coil, filter, wire, artificial heart valve, or annuloplasty ring in your heart or blood vessels? Yes No | Does your clothing (e.g., sportswear, yoga pants, etc.) have any metal-based fibers? Yes No |
| Do you have or have you ever had a cochlear implant? Yes No | Are you wearing a medication patch? (may need to remove) Yes No |
| Do you have a port (e.g., mediport, powerport) or breast tissue expander? Yes No | Do you have any implanted hardware such as screws, plates, pins, or rods? Yes No |
| Do you have an implanted shunt, catheter, or tube anywhere in your body? Yes No | Do you have any surgical clips, wires, or staples? Yes No |
| Do you have any of the following: penile implant, eyelid springs, eyelid weights, scleral buckle, or glaucoma shunt? Yes No | Do you have an IUD? (intrauterine device) Yes No |
| Are you or could you be pregnant? Yes No | Are there any other implants or metal objects in or on your body not listed above? If yes, please explain below. Yes No |

Please explain if you answered yes to any questions:

(Note to screeners: Do not scan without prior approval from center manager for anything indicated "Yes" in the first column)

SIGNATURE

DATE

SCREENER'S SIGNATURE

DATE