University of Delaware | Center for Biomedical and Brain Imaging

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