|  |  |  |
| --- | --- | --- |
|  | | MAGNETIC RESONANCE ENVIRONMENT SCREENING FORM |
| **magnet** | This MR system has a very strong static field that may be hazardous to individuals entering the magnet room if they have certain metallic, electronic, magnetic, or mechanical implants, devices or objects. Therefore, all individuals are required to fill out this form BEFORE entering the magnet room. Be advised, the magnet is ALWAYS ON. | |

1. Have you had prior surgery or an operation (eg. athroscopy, endoscopy, etc) of any kind? Yes No

If yes, please provide Date:       Type of Surgery:

1. Have you had an injury to the eye involving a metallic object (e.g. metallic slivers, foreign body)? Yes No

If yes, please describe:

1. Have you ever been injured by a metallic object (e.g. BB, bullet, shrapnel, welding accident, etc.)? Yes No

If yes, please describe:

1. Are you pregnant or suspect that you are pregnant? Yes No
2. Have you had a previous contrast agent reaction? Yes No

|  |  |
| --- | --- |
| **warning symbol** | **WARNING**: Certain implants, devices or objects may be hazardous to you in the MR environment or the magnet room. DO NOT ENTER the MR environment or the magnet room if you have any of the following implants, devices or objects.  **IMPORTANT:** Remove all metallic objects before entering the MR environment or magnet room. Loose metallic objects are especially prohibited. |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Yes No | Aneurysm clip(s) | Yes No | Dentures or partial plates (remove) |
| Yes No | Cardiac pacemaker, pacemaker wires, or stents | Yes No | Hearing aid (remove) |
| Yes No | Implanted cardioverter defibrillator (ICD) | Yes No | Metal object (ie keys, coins–must remove) |
| Yes No | Electronic or magnetically-activated implant or device (electrodes, wires, metallic filter or coil) | Yes No | Other implant(s) |
| Yes No | Neurostimulation system, spinal cord stimulator | Yes No | Breathing problem or motion disorder |
| Yes No | Implanted or transcutaneous bio-stimulator(spinal cord, bone growth/bone fusion, tens unit, etc.) | Yes No | Do you have claustrophobia? |
| Yes No | Insulin or other infusion pump | Internal Use Only  Field Strength: 3T  7T  MRI Technologist Comments: | |
| Yes No | Implanted drug infusion device |
| Yes No | Any type of prosthesis (heart valve, eyelid spring/wire, penile, limb, etc.) |
| Yes No | Shunt (spinal or intraventricular) |
| Yes No | Vascular access point and/or catheter |
| Yes No | Radiation seeds or implants |
| Yes No | Swan/Ganz or thermodilution catheter |
| Yes No | Medication patch (ie. nicotine, nitroglycerine) |
| Yes No | Wire mesh implant |
| Yes No | Surgical staples, clips or metallic sutures |
| Yes No | Joint replacement (hip, knee, etc.) |
| Yes No | Bone/joint pin, screw, nail, wire, plate, etc. |
| Yes No | Tissue expander (e.g. breast) |
| Yes No | IUD, diaphragm, or pessary |
| Yes No | Tattoo or permanent cosmetics |
| Yes No | Body piercing jewelry |

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.

MRI Participant:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Print Name Signature

MRI Technologist:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:       Print Name Signature