

PARTICIPANTS WITH ANY HISTORY OF IMPLANTS MUST BE APPROVED BY THE MRI SAFETY OFFICER BEFORE A MRI SCAN MAY BE PERFORMED WITHOUT EXCEPTION.

UCDAVIS IMAGING RESEARCH CENTER PRE-MRI SCREENING FORM

Date ____/____/____ | **Principal Investigator:** _____

Name _____ Height _____ Weight _____
Last name First name M.I.

Birth Date _____

1. Have you ever had surgery or similar invasive procedure in which medical devices may have been implanted? No Yes

If yes, please list:

Type: _____ Date: ____/____/____

Type: _____ Date: ____/____/____

2. Have you had any previous MRI imaging studies? No Yes

If yes, please list:

<u>Body part</u>	<u>Date</u>	<u>Facility Location</u>
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

3. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, shrapnel, foreign body)? No Yes

If yes, please describe: _____

For female subjects only:

4. Are you pregnant, or is there a possibility that you are pregnant?
(if unsure, please notify MRI operator or Principal Investigator) No Yes

5. Are you breast feeding? No Yes 6. Date of last menstrual period: ____/____/____

7. Are you taking any type of fertility medication or having fertility treatments? No Yes

8. Are you taking oral contraceptives or receiving hormone treatment? No Yes

9. Are you currently taking or have you recently taken any medication? No Yes
If yes, please list: _____

10. Do you have anemia or any diseases that affect your blood, or a history of renal disease? No Yes
If yes, please list: _____

11. Do you have a history of seizure disorder or epilepsy? No Yes

12. Do you have any drug allergies? No Yes
If yes, please list: _____

13. Have you ever had asthma, allergic reaction, respiratory disease, or any type of reaction to a contrast medium or dye used for an MRI or CT examination? No Yes
If yes, please describe: _____

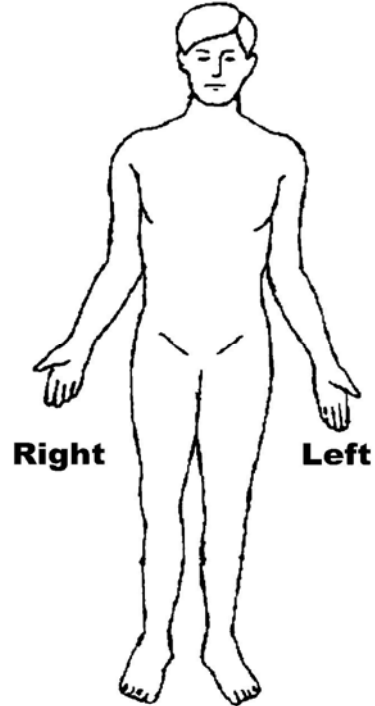
PARTICIPANTS WITH ANY HISTORY OF IMPLANTS MUST BE APPROVED BY THE MRI SAFETY OFFICER BEFORE A MRI SCAN MAY BE PERFORMED WITHOUT EXCEPTION.

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

- | | | |
|-----|----|---|
| Yes | No | Dental Hardware (e.g. metal crowns, braces, retainers) |
| Yes | No | Cardiac pacemaker |
| Yes | No | Implanted cardiac defibrillator |
| Yes | No | Aneurysm clip(s) |
| Yes | No | Carotid artery vascular clamp |
| Yes | No | Neurostimulator |
| Yes | No | Insulin or infusion pump |
| Yes | No | Implanted drug infusion device |
| Yes | No | Bone growth/fusion stimulator |
| Yes | No | Cochlear, otologic, or implant |
| Yes | No | Any type of prosthesis (eye, penile, etc.) |
| Yes | No | Heart valve prosthesis |
| Yes | No | Artificial limb or joint |
| Yes | No | Electrodes (on body, head, or brain) |
| Yes | No | Intravascular stents, filters, or coils |
| Yes | No | Shunt (spinal or intraventricular) |
| Yes | No | Vascular access port and/or catheter |
| Yes | No | Swan-Ganz catheter |
| Yes | No | Any implant held in place by a magnet |
| Yes | No | Transdermal Patch Delivery System (e.g. Nicotine,
(Remove before MRI)) |
| Yes | No | IUD or diaphragm |
| Yes | No | Tattooed makeup (eyeliner, lips, etc.) |
| Yes | No | Body piercing(s) (Remove before MRI) |
| Yes | No | Any metal fragments (including bullets, shrapnel) |
| Yes | No | Internal pacing wires |
| Yes | No | Aortic clip |
| Yes | No | Metal or wire mesh implants |
| Yes | No | Wire sutures or surgical staples |
| Yes | No | Harrington rods (spine) |
| Yes | No | Metal rods in bones |
| Yes | No | Joint replacement |
| Yes | No | Bone/joint in, screw, nail, wire, plate |
| Yes | No | Hearing aid (Remove before MRI) |
| Yes | No | Dentures (Remove before MRI) |
| Yes | No | Breathing disorder |
| Yes | No | Movement disorder |
| Yes | No | Claustrophobia |
| Yes | No | Anxiety |

Other, please explain _____

Please mark on the figure below, the location of any implant or metal inside of or on your body.



Before your MRI, please **remove all metallic objects** including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

Signature/Printed name of Person Completing Form

Date ____ / ____ / ____

Form completed by: _____ Patient/Subject _____ Relative: _____
Name & relationship to patient

Physician or other: _____
Name & relationship to patient

Signature/Printed name of Person Reviewing Form

Date ____ / ____ / ____