

UT Southwestern Advanced Imaging Research Center (AIRC)

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR RESEARCH SUBJECTS

Date ____/____/____

Name _____
Last name First name Middle Initial

Age _____ Height _____ Weight _____

Date of Birth ____/____/____ Male Female
month day year

Body Part to be Examined _____

Address _____

Telephone (home) (____) _____ - _____

City _____

Telephone (work) (____) _____ - _____

State _____ Zip Code _____

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

If yes, please indicate the date and type of surgery:

Date ____/____/____ Type of surgery _____

Date ____/____/____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? No Yes

If yes, please list: Body part Date Facility

MRI _____ _____ _____

CT/CAT Scan _____ _____ _____

X-Ray _____ _____ _____

Ultrasound _____ _____ _____

Nuclear Medicine _____ _____ _____

Other _____ _____ _____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes

If yes, please describe: _____

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

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes

If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? No Yes

If yes, please list: _____

7. Are you allergic to any medication? No Yes

If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No Yes

If yes, please list: _____

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures? No Yes

If yes, please describe: _____

For female patients:

10. Date of last menstrual period: ____/____/____ Postmenopausal? No Yes

11. Are you pregnant or experiencing a late menstrual period? No Yes

12. Are you taking oral contraceptives or receiving hormonal treatment? No Yes

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

If yes, please describe: _____

14. Are you currently breastfeeding? No Yes

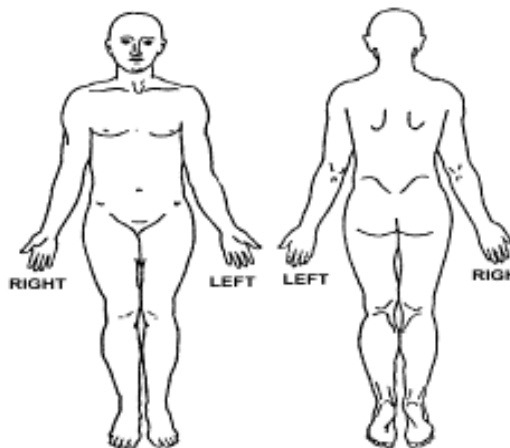


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Do you have any of the following:

- Aneurysm clip(s) No Yes
- Implanted cardioverter defibrillator (ICD) No Yes
- Cardiac pacemaker No Yes
- Electronic implant or device No Yes
- Magnetically-activated implant or device No Yes
- Neurostimulation system No Yes
- Spinal cord stimulator No Yes
- Cochlear, otologic, or other ear implant No Yes
- Bone growth/bone fusion stimulator No Yes
- Internal electrodes or wires No Yes
- Insulin or other infusion pump No Yes
- Implanted drug infusion device No Yes
- Any type of prosthesis (eye, penile, etc.) No Yes
- Heart valve prosthesis No Yes
- Eyelid spring or wire No Yes
- Artificial or prosthetic limb No Yes
- Metallic stent, filter, or coil No Yes
- Shunt (spinal or intraventricular) No Yes
- Radiation seeds or implants No Yes
- Medication patch (Nicotine, nitroglycerine) No Yes
- Any metallic fragment or foreign body No Yes
- Wire mesh implant No Yes
- Tissue expander (e.g., breast) No Yes
- Surgical staples, clips, or metallic sutures No Yes
- Joint replacement (hip, knee, etc.) No Yes
- Bone/joint pin, screw, nail, wire, plate, etc. No Yes
- IUD, diaphragm, or pessary No Yes
- Dentures or partial plates No Yes
- Tattoo or permanent makeup No Yes
- Body piercing jewelry No Yes
- Other implant _____ No Yes
- Hearing aid No Yes
- (Remove before entering MR system room)* No Yes
- Breathing problem or motion disorder No Yes
- Claustrophobia No Yes

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



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____

Form Completed By: Patient Relative MR Tech _____
 Print name Relationship to patient

Form Information Reviewed By: _____
 Print name Signature

MRI Technologist Research Coordinator Level 2 Student/Post-doc Other _____