

3.0 T MRI PRE-ENTRY SCREENING FORM

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This form to be used for: Screening of research subjects immediately prior to MRI study (Completed form filed at CFMRI)
Screening of assistants who enter the MRI suite – e.g. nurse, parent (Completed form filed at CFMRI)

Instructions for completing this form, and duplicate forms available from <http://cfmri.ucsd.edu/forms.html>

Principal investigator / Lab _____ Subject Number _____ Height _____ Weight _____

IRB protocol # _____ Date of MRI study ____ / ____ / ____ Time of MRI study _____



Some of the following items may be hazardous to your safety or may interfere with the MRI exam. Please check the correct answer for each of the following. If you checked yes, please give more information. E.g. Type of material? How long ago? Use the diagram to indicate where on your body?

- 1. Yes No Do you have a heart pacemaker?
- 2. Yes No Is there a possibility of metal in your head? (e.g., aneurysm clips, do not include dental work)
- 3. Yes No Is there a possibility of metal in your eyes or have you ever needed an eyewash having worked with metals?
- 4. Yes No Do you have an implanted medical device? (cochlear implant, metal ear tubes, tens unit, bone stimulator, insulin or other medication pump, automatic defibrillator, internal pacing wires).
- 5. Yes No Is there any possibility that you may be pregnant?
- 6. Yes No Have you had any metallic dental implants (posts, crowns) within the last 6 weeks?
- 7. Yes No Have you had any bone, tendon, spine, or joint surgery within the last 6 weeks?
- 8. Yes No *[Research subjects only:]* Do you weigh more than 300 lbs (135 kg)?

- 9. Yes No Do you suffer with claustrophobia?
- 10. Yes No Do you have any medical problems when you lie flat on your back? (breathing problems, back pain, nausea)
- 11. Yes No Do you have an IUD that may contain copper, or a contraceptive diaphragm?
- 12. Yes No Have you had any stents, clips, or surgery to any of any of your vessels (carotid artery vascular clamp, coronary stent, aortic clips, IVC filter, coils for blocked arteries)
- 13. Yes No Do you have metal anywhere else in your body? (spinal rods, dental work, piercings, shrapnel, buckshot, bullets) – please indicate where on your body using the diagram below
- 14. Yes No Do you have any piercings that can't be removed?
- 15. Yes No Do you have a cerebrospinal fluid (CSF) shunt? (treatment for hydrocephalus or water on the brain)
- 16. Yes No Do you have tattooed eyeliner, tattooed eyebrows or Bigen hair dye?
- 17. Yes No Have you had any previous surgery? (give details, and indicate where on your body using the diagram below)
Details: _____ Date: ____ / ____ / ____
Details: _____ Date: ____ / ____ / ____
- 18. Yes No Have you had any medical condition that has prevented you from completing an MRI exam in the past?
- 19. Yes No *[If medications or other substances are administered:]* Do you suffer with asthma or allergies to any medication?
- 20. Yes No Do you have a transdermal medicated patch? (nicotine patch, contraceptive patch, medicated pain relief patch)
- 21. Yes No Do you wear a hearing aid or dentures?
- 22. Yes No Are you wearing athletic clothing or compression garments with “silver-technology” or marketed as antimicrobial (e.g., Lululemon, Athleta, Columbia “Omniheat”, Under Armour, Tommy Copper, Juzo USA)?
- 23. Yes No Are you wearing magnetic eyeliner, mascara, or false eyelashes?

Actions taken: _____

If any responses above are checked "yes", detail here the actions taken before scanning subject.

I certify that I have screened this subject, and there are no contraindications to entering the MRI scanner room. This form is valid only on the day it is completed.

Signature of MRI scanner operator

Printed name of MRI scanner operator

____ / ____ / ____
Date

