



# 3.0 T MRI Procedure Screening Form for Personnel

The MRI system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. Therefore, all individuals are required to complete this form BEFORE entering the MR environment or system room. **Be advised, the MRI system magnet is ALWAYS on.**

Questions about this form or the INST screening process ,please call 662-325-8739.

## Participant Information

Date: \_\_\_/\_\_\_/\_\_\_ Principal Investigator / Lab \_\_\_\_\_ Subject Number \_\_\_\_\_

Name: \_\_\_\_\_  
Last Name First Name Middle Initial

Male Female Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_ Telephone (home) (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

City \_\_\_\_\_ Telephone (cell) (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone (work) (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_

Physician's Name & Address \_\_\_\_\_

## Screening Information

- Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? Yes No  
If yes, please indicate date and type of surgery: Date: \_\_\_/\_\_\_/\_\_\_ Type of surgery \_\_\_\_\_
  - Have you had an injury to the eye involving a metallic object (e.g., metallic slivers, foreign body)? Yes No  
If yes, please describe: \_\_\_\_\_
  - Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? Yes No  
If yes, please describe: \_\_\_\_\_
  - Are you currently taking or have recently taken any medication? Yes No If  
yes, please list: \_\_\_\_\_
  - Do you have drug allergies or have you had an allergic reaction? Yes No  
If yes, please describe: \_\_\_\_\_
  - Have you had a prior diagnostic imaging study or examination? Yes No  
If yes, please list:
 

	Body Part	Date	Facility
MRI	_____	___/___/___	_____
CT/CAT Scan	_____	___/___/___	_____
X-Ray	_____	___/___/___	_____
  - Have you experienced any problem related to a previous MRI examination or MR procedure? Yes No  
If yes, please list: \_\_\_\_\_
  - 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?
- For female participants:**
- Date of last menstrual period: \_\_\_/\_\_\_/\_\_\_ Postmenopausal? Yes No
  - Are you pregnant, suspect you are pregnant, or experiencing a late menstrual period? Yes No
  - Are you currently breastfeeding? Yes No

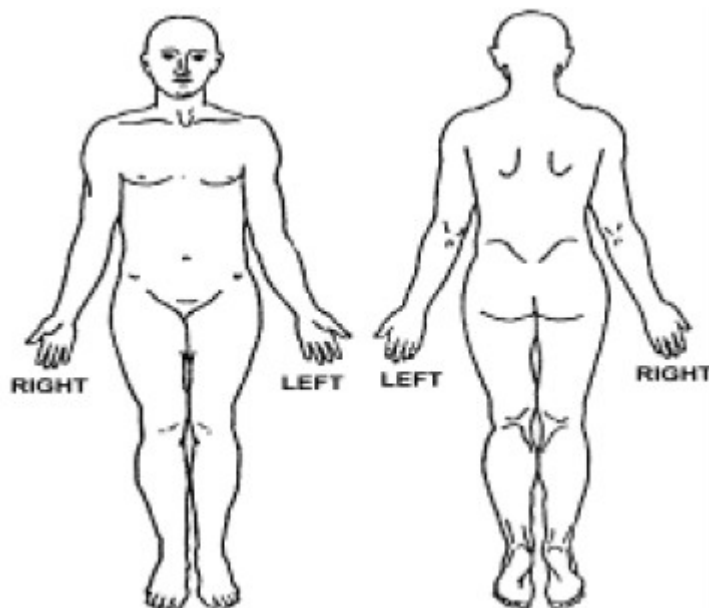


**Warning:** Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment or MR system room if you have any question or concern regarding an implant, device, or object.

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 check yes, please give more information. (E.g. Type of material? How long ago?) Use the diagram to indicate the location on your body.

Yes	No	Aneurysm clip (s)	Yes	No	Harrington rods (spinal rod)
Yes	No	Cardiac pacemaker	Yes	No	Bone growth/bone fusion stimulator
Yes	No	Implanted cardioverter defibrillator (ICD)	Yes	No	Eyelid spring or wire
Yes	No	Heart valve prosthesis	Yes	No	Metallic stent, filter, or coil
Yes	No	Aortic clips	Yes	No	Shunt (spinal or intraventricular)
Yes	No	Carotid artery vascular clamp	Yes	No	Medication patch (Nicotine, Nitroglycerine)
Yes	No	Vascular access port or catheters	Yes	No	Any metallic fragment or foreign body
Yes	No	Venous umbrella/IVC filter/Greenfield filter	Yes	No	Hernia repair (mesh patch)
Yes	No	Electronic implant or device	Yes	No	Wire mesh implant
Yes	No	Magnetically-activated implant or device	Yes	No	Tissue expander (e.g., breast)
Yes	No	Neurostimulation system	Yes	No	Surgical staples, clips, or metallic sutures
Yes	No	Spinal cord stimulator	Yes	No	Bone/joint pin, screw, nail, wire, plate, etc.
Yes	No	Hearing aid	Yes	No	Wire sutures or surgical staples
Yes	No	Cochlear, otologic, or other ear implant	Yes	No	Joint replacement (hip, knee, etc.)
Yes	No	Ear tubes	Yes	No	IUD, diaphragm, or pessary
Yes	No	Insulin or other infusion pump	Yes	No	Dentures, partial plates, or braces
Yes	No	Implanted drug infusion device	Yes	No	Colored contact lenses
Yes	No	Implant held in place by a magnet	Yes	No	Hair piece, wig, or toupee
Yes	No	Any type of prosthesis or implant	Yes	No	Facelift or other cosmetic surgery
Yes	No	Electrodes (on body, head, or brain)	Yes	No	Tattoo or permanent makeup
Yes	No	Artificial or prosthetic limb	Yes	No	Body piercing jewelry
Yes	No	Any metallic fragment or foreign body	Yes	No	Breathing problem or motion disorder
Yes	No	Any external or internal metallic object	Yes	No	Claustrophobia
Yes	No	Internal electrodes or wires	Yes	No	Other implant_____

Please mark on the figures 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, belt, clothing with metal fasteners, and clothing with metallic threads.

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.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

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 environment.

Signature of Person Completing Form: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Form Information Reviewed By: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

MRI Technician                      Nurse                      Radiologist                      Other \_\_\_\_\_

Additional Screenings: Please note if anything has changed on this form from initial screening.

I attest that the above information is correct and current since the previous screening.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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