

**BROWN UNIVERSITY MRF MAGNETIC RESONANCE (MR) PROCEDURE SCREENING
FORM FOR RESEARCH SUBJECTS**

Date ____/____/____

Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

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

Address _____ Telephone (home) (____) ____-____

City _____

State _____ Zip Code _____

1. Have you ever had surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? No Yes
 If yes, please indicate date and type of surgery:

Date ____/____/____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination with MRI? No Yes
 If yes, please list:

	Body part	Date	Facility
MRI	_____	____/____/____	_____
	_____	____/____/____	_____

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 done any welding, grinding or cutting of metal in your lifetime? No Yes

6. Did you wear safety protection for your eyes? No Yes

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

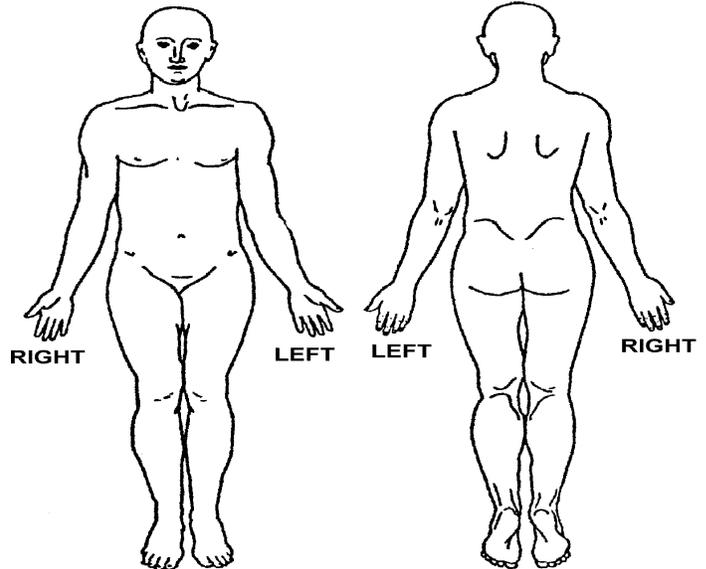
If yes, please describe: _____

Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, MR spectroscopy, functional MRI, etc.). If you have any question regarding an implant, device, or object, please discuss this with the MRI Technologist or Radiologist BEFORE entering the MR environment or MR system room.

Please indicate if you have any of the following:

- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Aneurysm clip(s)
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or triple lumen catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- 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 IUD or diaphragm
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Breathing disorder
- Yes No Motion disorder or tremors
- Yes No Claustrophobia
- Yes No Hearing aid
- (Remove before entering MR system room)*
- Yes No Other _____

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 including 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 in the material.

Please see the MRI Technologist 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 have read and understand the entire contents of this form and have 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 _____
Signature

Date ____/____/____

Form Completed By Patient Relative _____
Print name

Relationship to patient

Form Information Reviewed By _____
Print name

Signature