

## Duke-UNC Brain Imaging and Analysis Center: Participant MRI Screening Form

All individuals entering the MRI suite must fill out this information to the best of their knowledge. Any potential contraindications must be reviewed with the individual's medical record and the BIAC MR Safety Committee before being cleared to enter the scanner bore.

***Before you may enter the scanner room, you must remove all metallic objects.***

- |  |  |
|--|--|
| <input type="checkbox"/> All contents of pockets, including back pockets<br><input type="checkbox"/> Wrist watch, any bracelets<br><input type="checkbox"/> Hair pins, clips, weaves, fasteners<br><input type="checkbox"/> Pins or badges on shirt<br><input type="checkbox"/> Belt with metal (e.g., buckle) | <input type="checkbox"/> Shoes that contain any metal (e.g., steel tipped)<br><input type="checkbox"/> Hearing aids or other electronic devices<br><input type="checkbox"/> Pagers, cell phones, PDAs<br><input type="checkbox"/> Dentures or removable retainer<br><input type="checkbox"/> Necklaces, chains |
|--|--|

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

Participant ID (optional): \_\_\_\_\_ Birthdate: \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

1. Do you currently have a fever or other acute illness? (e.g. head cold, flu)  Yes  No

If yes, please describe: \_\_\_\_\_

2. Do you wear glasses or contact lenses?  Yes  No

If yes, please specify prescription \_\_\_\_\_

3. Have you had any previous MRI studies or been in a MR scanner?  Yes  No

If yes, please provide the following information about your most recent scan:

Date: \_\_\_\_\_ Facility: \_\_\_\_\_ Body part: \_\_\_\_\_

If yes, did you have any problems during this scan? \_\_\_\_\_

4. Are you claustrophobic?  Yes  No

5. Have you ever had an injury to the eye involving a metallic object?  Yes  No

(e.g. metallic slivers, shavings, foreign body)?

If yes, please describe: \_\_\_\_\_

6. Have you ever worked with metal (grinding, fabricating, etc.)?  Yes  No

If yes, please describe: \_\_\_\_\_

If yes, did you wear eye protection 100% of the time?  Yes  No

7. Have you ever had **eye** surgery?  Yes  No

If yes, please describe: \_\_\_\_\_

Protocol: \_\_\_\_\_

Exam Number: \_\_\_\_\_

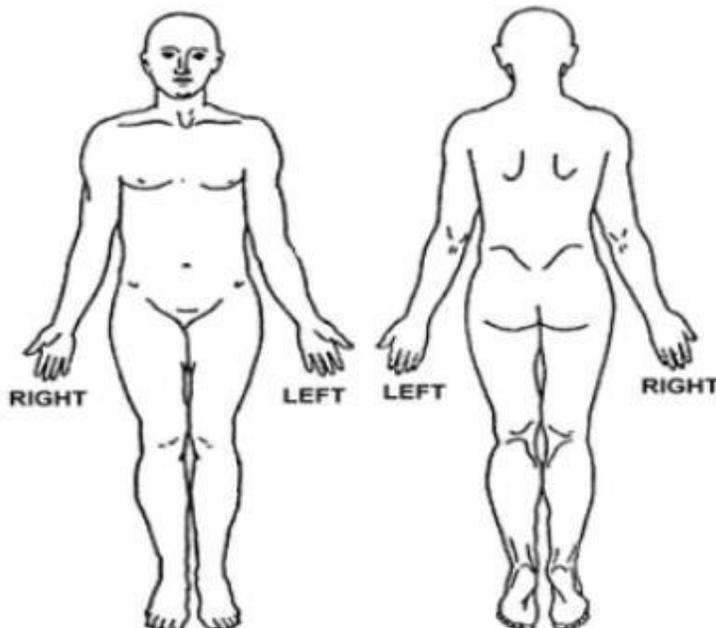
Date: \_\_\_\_\_

7. Are you currently taking any medication?  Yes  No  
a. If yes, please list \_\_\_\_\_  
\_\_\_\_\_
8. Do you have anemia or any diseases that affect your blood?  Yes  No  
a. If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
9. Do you have a history of strokes, seizures, brain tumors, head trauma,  
or other neurological disorders?  Yes  No  
a. If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
10. Do you have a breathing disorder (e.g., asthma, apnea, COPD)?  Yes  No  
a. If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
11. Do you have a heart condition (e.g. arrhythmias)?  Yes  No  
a. If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_
12. Do you have or movement disorder (e.g. Parkinson's or Huntington's disease)?  Yes  No  
a. If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

13. Please list any surgeries or other invasive medical procedures in **as much detail as possible:**

Please list or mark the location of any implant or metal inside of or on your body in the image below.

**\*For the spine, please note where i.e neck, back, lower back\***



**⚠ 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 questions or concerns regarding an implant, device, or on object.

Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR magnet is ALWAYS on.

**Please indicate if you have any of the following:**

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s)                               |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker                              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD)     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electronic implant or device                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetically-activated implant or device       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes or wires                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic, or other ear implant       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or infusion pump                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted drug infusion device                 |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid spring or wire                          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (i.e. breast)                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Neurostimulation system                        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Spinal cord stimulator                         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/bone fusion stimulator             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any metallic fragment or foreign body          |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial or prosthetic limb                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc.)     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart valve prosthesis                         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metallic stent, filter, or coil                |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intraventricular)             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement (hip, knee, etc.)            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical staples, clips, or metallic sutures   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port and/or catheter           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation seeds or implants                    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wire mesh implant                              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD or diaphragm containing metal              |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medication patch (Nicotine, Nitroglycerine)    |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures or partial plates                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dental fillings, crowns, or bridges            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dental implants or permanent retainers         |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo or permanent makeup                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Body piercing or jewelry                       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing aid (remove before entering MRI)       |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other implant _____                            |

*If needed*, please use this space to describe in detail any additional information related to potential metal fragments or implants in 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, cell phone, eyeglasses, beeper, 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, and clothing with metallic threads. You will be asked to wear ear plugs to protect your hearing during the scan.**

**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 procedure that I am about to undergo.