Protocol: _____ Exam Number: _____ Date:_____

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.

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

First Name: _____ Middle Initial: _____ Last Name: _____

Participant ID *(optional)*: _____ Birthdate: _____

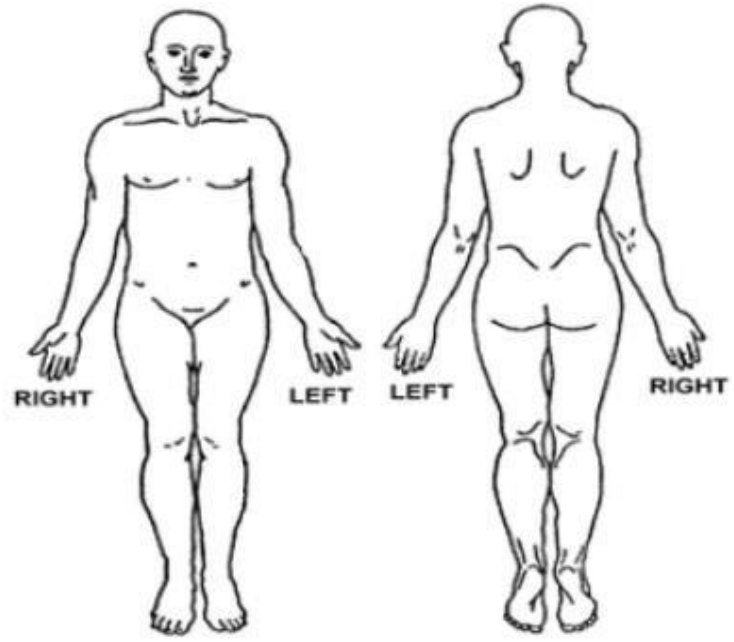
Height _____ Weight _____

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: _____

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.

Protocol: _____ Exam Number: _____ Date:_____

Please indicate if you have any of the following:

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

_____ _____ _____

Signature of Participant Completing Form | Signature of Staff Screening the Participant | Date