York MRI Facility

Magnetic Resonance (MR) Safety Screening Form

Name _____ **Height** _____
Last First MI **Weight** _____

Date of Birth _____/_____/_____ ☐ Male ☐ Female ☐ Other
Month Day Year

Do you have: **Cardiac pacemaker or implantable cardioverter defibrillator (ICD)** ☐ **Yes** ☐ **No**
Aneurysm clip ☐ **Yes** ☐ **No**
Are you: Claustrophobic ☐ Yes ☐ No
Are you currently taking any medications? ☐ Yes ☐ No
List: _____

Have you ever had an injury involving a metallic object or fragment? ☐ Yes ☐ No
Have you ever worked in a metal shop? ☐ Yes ☐ No
Possibility of pregnancy? ☐ Yes ☐ No ☐ Not applicable

Brain/Head Surgery ☐ Yes ☐ No
List type/date
_____

Heart/Chest Surgery ☐ Yes ☐ No
List type/date *Retained pacer wires* ☐ Yes ☐ No
_____

Ear/Eye Surgery ☐ Yes ☐ No
List type/date
_____

Other Surgery ☐ Yes ☐ No
List type/date
_____

Artificial Implants/Mechanical Devices .
List type/date ☐ Yes ☐ No
_____

Underwire bra	☐ Yes ☐ No
Intrauterine device (IUD)	☐ Yes ☐ No
Piercings (ears or body piercings)	☐ Yes ☐ No
Hearing aid or cochlear implant	☐ Yes ☐ No
Permanent retainer or braces	☐ Yes ☐ No
Dentures or partials	☐ Yes ☐ No
History of bullets, shrapnel or BBs	☐ Yes ☐ No
History of seizures	☐ Yes ☐ No
Hair piece, wig or hair extensions	☐ Yes ☐ No
Medication patch	☐ Yes ☐ No
Tattoo or permanent makeup	☐ Yes ☐ No
Stent, filter	☐ Yes ☐ No

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

I attest that the above information is correct to the best of my knowledge. I have read and understood the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Signature of person completing form: _____ **Date** ___/____/____
M D Y

Form completed by: ☐ MRI participant ☐ Other (specify)_____

Reviewed by: _____ **PI of study** _____