York MRI Facility

Magnetic Resonance (MR) Safety Screening Form

Name _____ **Height** _____
Last *First* *Middle* **Weight** _____

Date of Birth ___/___/___
Month *Day* *Year*

☐ Male ☐ Female ☐ Other

Do you have a **Cardiac Pacemaker** or **Implantable Cardioverter Defibrillator** (ICD)? ☐ Yes ☐ No
Do you have an **Aneurysm Clip**? ☐ Yes ☐ No
Are you Claustrophobic? ☐ Yes ☐ No
Are you currently taking any medications? 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? ☐ Not Applicable ☐ Yes ☐ No

Surgery

Brain/Head Surgery? ☐ Yes ☐ No
Type/Date: _____

Heart/Chest Surgery? ☐ Yes ☐ No
Type/Date: _____

Eye/Ear Surgery? ☐ Yes ☐ No
Type/Date: _____

Other Surgery? ☐ Yes ☐ No
Type/Date: _____

Artificial Implants/Mechanical Devices? ☐ Yes ☐ No
Type/Date: _____

Please Indicate if you have any of the following

Piercings (ear or body)	☐ Yes ☐ No	Medication Patch	☐ Yes ☐ No
Hearing Aid or Cochlear Implant	☐ Yes ☐ No	Tattoo or Permanent Makeup	☐ Yes ☐ No
Permanent Retainer/Braces	☐ Yes ☐ No	Stent or Filter	☐ Yes ☐ No
Dentures or Partials	☐ Yes ☐ No	Antimicrobial Clothing	☐ Yes ☐ No
History of Bullets/Shrapnel/BBs	☐ Yes ☐ No	Intrauterine device (IUD)	☐ Yes ☐ No
History of Seizures	☐ Yes ☐ No	Underwire bra	☐ Yes ☐ No
Hair piece/wig/hair extensions	☐ Yes ☐ No	Magnetic Eyelash Extensions	☐ 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 magnet 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** _____