

CMRR Subject Safety Screening Form

(For research subjects and anyone accompanying them into the magnet room)

Name: _____ Date of Birth (mm/dd/yy): ____/____/____
Height: ____ft ____in Weight: ____lbs

Section 1: Items of Interest

- | | | | |
|-----|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----|
| 1. | Do you wear a hearing aid? If yes, it will need to be removed. | No | Yes |
| 2. | Are you currently wearing a diaphragm for birth control?
<i>If yes, it will need to be removed.</i> | No | Yes |
| 3. | Are you wearing a transdermal drug delivery patch? Examples: birth control, nicotine, nitro, fentanyl, etc.
If yes, it will need to be removed (under direction of your doctor) | No | Yes |
| 4. | Do you have any of the following conditions?
Hypertension____ Hypotension____ Diabetes____ Cardiovascular Disease____ Fever____ None____ | | |
| 5. | Have you had any previous surgeries? If yes, please describe. | No | Yes |
| | | | |
| 6. | Have you taken any medication or supplements today that make you unusually tired or sleepy (examples: sedatives, allergy medications)? | No | Yes |
| 7. | Are you claustrophobic (fear of closed spaces)?
No____ Mild____ Moderate____ Severe____ | | |
| 8. | Are you currently wearing an underwire bra? | No | Yes |
| 9. | Are you currently wearing any clothing that is considered anti-odor, anti-microbial, or anti-bacterial? <i>If yes, it will need to be removed.</i> | No | Yes |
| 10. | Do you wear colored contacts? If yes, they will need to be removed. | No | Yes |
| 11. | Are you wearing any removable jewelry? If yes, it will need to be removed. | No | Yes |
| 12. | Are you currently wearing a wig? If yes, it will need to be removed. | No | Yes |
| 13. | Are you currently wearing make-up, hair gel, glittery nail polish, or have you recently used powdered hair dye? | No | Yes |

Section 2: Signature required of one of the following: anyone listed on IRB protocol as able to consent, CMRR MR Technologist, or MR Professional

- | | | | |
|-----|----------------------------------------------------------------------------------------------------|----|-----|
| 14. | Do you wear braces on your teeth, have a permanent retainer, removable bridgework, or false teeth? | No | Yes |
| 15. | Do you have any tattoos or permanent make-up such as eyeliner?
If yes, where: _____ | No | Yes |
| 16. | Do you have any non-removable body piercings?
If yes, where: _____ | No | Yes |
| 17. | Do you have hair extensions or weaves? | No | Yes |

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Section 3: MR Professional Signature Required (unless otherwise stated)

18. Are you currently using (wearing) an Intrauterine Device (IUD)? No Yes
If yes, indicate which type: _____
(NOTE: If Mirena, Paragard, or Skyla no MR-Professional signature required)
19. Do you have any reason to believe that you are, or could be, pregnant? No Yes
20. Have you ever been employed as a metalworker (grinder, welder, etc.)? No Yes
21. Do you engage in activities (hobbies, etc.) that involve working with metal? No Yes
22. Have you ever had metal fragments in your eyes (even if they were removed)? No Yes
23. Do you have a heart pacemaker, defibrillator, or other implanted device? No Yes
24. Do you have any of the following?

These devices may be hazardous to your health in the presence of magnetic fields:

Cardiac Pacemaker	No	Yes	Implanted Cardiac Defibrillator	No	Yes
Aortic Clip	No	Yes	Cochlear, Otologic, or Ear Implant	No	Yes
Internal Pacing Wires	No	Yes	Intravascular Stents, Filters, or Coils	No	Yes
Swan-Ganz Catheter	No	Yes	Vascular Access Port and/or Catheter	No	Yes
Aneurysm Clip(s)	No	Yes	Shunt (Spinal or Intraventricular)	No	Yes
Heart Valve Prosthesis	No	Yes	Any Type of Prosthesis (Eye, Penile, etc.)	No	Yes
Neurostimulator or DBS Device	No	Yes	Electrodes (on Body, Head, or Brain)	No	Yes
Metal Rods in Bones	No	Yes	Artificial Limb or Joint Replacement	No	Yes
Harrington Rods (Spine)	No	Yes	Bone/Joint Pin, Screw, Nail, Wire, Plate	No	Yes
Metal or Wire Mesh Implants	No	Yes	Wire Sutures, Staples, or Suture Anchors	No	Yes
Bone Growth/Fusion Stimulator	No	Yes	Any Implant held in place by a Magnet	No	Yes
Insulin Pump or Infusion Device	No	Yes	Any Metal Fragments in your Body	No	Yes
Carotid Artery Vascular Clamp	No	Yes	Any other Implants in your Body	No	Yes

YOU ARE REQUIRED TO WEAR EARPLUGS AND/OR EARPHONES DURING THE MRI EXAMINATION

I attest 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.

Signature of Research Participant or their Representative

Date: ____/____/____

Representative's Relationship to Research Participant

Name of Person Administering Screening Form

Signature of Person Administering Screening Form

Date: ____/____/____

Signature or Preapproval Documentation Required for All Affirmative Answers in Sections 2 & 3

Affirmative answer(s) cleared by: _____
Name Signature or Attach Preapproval Documentation