CMRR Subject Safety Screening Form

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

Name:_____ Date (mm/dd/yy):___/___/_____

Height:___ft ____in Weight:_____lbs Date of Birth (mm/dd/yy): ___/___/_____

Section 1: Items of Interest

1.	Do you wear a hearing aid? If yes, it will need to be removed.		No	Yes
2.	Do you wear colored contacts? If yes, they will need to be removed.		No	Yes
3.	Are you wearing any removable jewelry? If yes, it will need to be removed.		No	Yes
4.	Are you currently wearing a diaphragm for birth control? If yes it will need to be removed.	N/A	No	Yes
5.	Are you wearing a transdermal drug delivery patch? Examples: birth control, nicotine, nitro, fentanyl, etc. If yes, it will need to be removed.		No	Yes
6.	Are you currently wearing a wig? If yes, it will need to be removed.		No	Yes
7.	Are you currently wearing make-up, hair gel, glittery nail polish, or have you recently used powdered hair dye?		No	Yes
8.	Are you currently wearing an underwire bra?	N/A	No	Yes
9.	Are you currently wearing any clothing that is considered anti-odor, anti-microbial, or anti-bacterial? If yes, it will need to be removed.		No	Yes
10.	Have you had any previous surgeries? If yes, please describe.		No	Yes

11. Please check if you have any of the following conditions?
    Hypertension___ Hypotension___ Diabetes___ Cardiovascular Disease___ Fever___
12. Are you claustrophobic (fear of closed spaces)?
    No___ Mild___ Moderate___ Severe___
13. Please list all medications (OTC and prescription) you took today or are taking regularly. (try to include the name of the medicine, dose, how often, and time of last dose)

Section 2: PI or Co-Investigator (listed on IRB protocol), CMRR MR Technologist, or MR Professional Signature Required

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

Section 3: MR Professional Signature Required

18. Are you currently using (wearing) an Intrauterine Device (IUD)? N/A No Yes
    If yes, type:_____ (If Mirena, Paragard, or Skyla no signature required)
19. Have you ever had metal fragments in your eyes (even if they were removed)? No Yes
20. Do you have any reason to believe that you are pregnant? N/A No Yes
21. Have you ever been employed as a metalworker (grinder, welder, etc.)? No Yes
22. Do you have a heart pacemaker, defibrillator, or other implanted device? No Yes
23. Do you have any of the following?
    All 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 Prothesis (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			

NOTE: 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.

_____ Date:___/___/_____
Signature of Research Participant or their Representative

_____
Representative's Relationship to Research Participant

_____ _____ Date:___/___/____
Name of Person Administering Screening Form Signature of Person Administering Screening Form

Investigator Use Only

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

_____ _____ Date:___/___/_____
Name of Witness Signature of Witness

*** Witness Name/Signature only required if signature or preapproval documentation for affirmative answer is unavailable.**