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3.0 T MRI PRE-ENTRY SCREENING FORM	UCSD Center for fMRI, 9500 Gilman Drive, La Jolla, CA 92093-0677 Tel: (858) 822-0513 Fax:(858) 822-0608

This form to be used for: Screening of research subjects immediately prior to MRI study (Completed form filed at CFMRI)
Screening of assistants who enter the MRI suite – e.g. nurse, parent (Completed form filed at CFMRI)

Instructions for completing this form, and duplicate forms available from http://cfmri.ucsd.edu/forms.html

Principal investigator / Lab ______________________ Subject Number __________ Weight ______

IRB protocol # ____________ Date of MRI study ____/____/____ Time of MRI study ______________

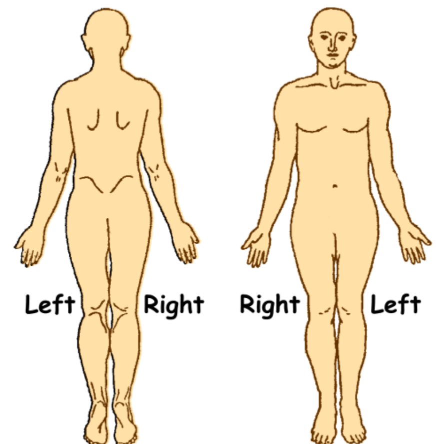
Some of the following items may be hazardous to your safety or may interfere with the MRI exam. Please check the correct answer for each of the following. If you checked yes, please give more information. E.g. Type of material? How long ago? Use the diagram to indicate where on your body?

1. ☐ Yes ☐ No Do you have a heart pacemaker?
2. ☐ Yes ☐ No Is there a possibility of metal in your head? (e.g. aneurysm clips, do not include dental work)
3. ☐ Yes ☐ No Is there a possibility of metal in your eyes or have you ever needed an eyewash having worked with metals?
4. ☐ Yes ☐ No Do you have an implanted medical device? (cochlear implant, metal ear tubes, tens unit, bone stimulator, insulin or other medication pump, automatic defibrillator, internal pacing wires).
5. ☐ Yes ☐ No Have you had any metallic dental implants (posts, crowns) within the last 6 weeks?
6. ☐ Yes ☐ No Have you had any bone, tendon, spine or joint surgery within the last 6 weeks?
7. ☐ Yes ☐ No [*Research subjects only:*] Do you weigh more than 300 lbs (135 kg)?

8. ☐ Yes ☐ No Is there any possibility that you may be pregnant?
9. ☐ Yes ☐ No Do you suffer with claustrophobia?
10. ☐ Yes ☐ No Do you have any medical problems when you lie flat on your back? (breathing problems, back pain, nausea)
11. ☐ Yes ☐ No Do you have an IUD that may contain copper, or a contraceptive diaphragm?
12. ☐ Yes ☐ No Have you had any stents, clips or surgery to any of any of your vessels (carotid artery vascular clamp, coronary stent, aortic clips, IVC filter, coils for blocked arteries)
13. ☐ Yes ☐ No Do you have metal anywhere else in your body? (spinal rods, dental work, piercings, shrapnel, buckshot, bullets) – please indicate where on your body using the diagram below
14. ☐ Yes ☐ No Do you have any piercings that can't be removed?
15. ☐ Yes ☐ No Do you have a cerebrospinal fluid (CSF) shunt? (treatment for hydrocephalus or water on the brain)
16. ☐ Yes ☐ No Do you have tattooed eyeliner, tattooed eyebrows or Bigen hair dye?
17. ☐ Yes ☐ No Have you had any previous surgery? (give details, and indicate where on your body using the diagram below)
    Details: ______________________ Date: ____/____/____
    Details: ______________________ Date: ____/____/____
18. ☐ Yes ☐ No Have you had any medical condition that has prevented you completing an MRI exam in the past?
19. ☐ Yes ☐ No [*If medications or other substances are administered:*] Do you suffer with asthma or allergies to any medication?
20. ☐ Yes ☐ No Do you have a transdermal medicated patch? (nicotine patch, contraceptive patch, medicated pain relief patch)
21. ☐ Yes ☐ No Do you wear a hearing aid or dentures?

Actions taken: ______________________________

If any responses above are checked "yes", detail here the actions taken before scanning subject.



I certify that I have screened this subject, and there are no contraindications to entering the MRI scanner room. This form is valid only on the day it is completed.

____
Signature of MRI scanner operator

______________________________ ____/____/____
Printed name of MRI scanner operator Date