File completed form with PI

3.0 T MRI RECRUITMENT / ADVANCED SCREENING

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This form to be used for: Primary screening of research subjects being recruited by principal investigator (File completed form with PI)

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

Principal investigator / Lab _____

Subject Weight _____ Subject Number _____

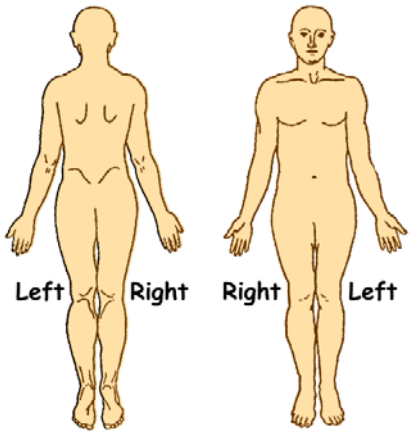
Name _____
Last name First name M.I.

Birthdate _____ Email Address _____

Address _____ City _____

State _____ Zip Code _____

Phone (____) _____ (____) _____ (____) _____
Home Work Cell/Pager



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 above
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 above)
    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?

_____ _____ ____/____/____
Name of person completing form (please print) Signature Date

_____ _____ ____/____/____
Name of CFMRI safety personnel reviewing form (if secondary review needed) Signature Date