UNIVERSITY of VIRGINIA HEALTH SYSTEM
Radiology & Medical Imaging
Medical Imaging Research

RADIOLOGY DIVISION OF MRI RESEARCH
PATIENT VOLUNTEER SCREENING FORM

IRB Number: ____________
Subject ID: ____________
Scanner: ____________

PRINT NAME: ____________ **DOB:** ____________ **HEIGHT:** ________ **WEIGHT:** ________

Because certain metallic objects may interfere with the strong magnetic field used for this imaging procedure, and to ensure safe and satisfactory study, it is necessary that you answer the following questions.

Have you ever:	**YES**	**NO**
Had a surgery resulting in a metallic implant?..	☐	☐
Been a machinist, welder, metal worker or lathe operator?...	☐	☐
Been hit in the face or eye with a piece of metal? (*including metal shavings, slivers, bullets, or BBs*)...........	☐	☐
Had a piece of metal removed from your eye?	☐	☐
Had a MRI examination?...	☐	☐
Are you:		
Claustrophobic (do you have a fear of close places)?...	☐	☐
Allergic to any medications?...	☐	☐
Pleaselist____		
Pregnant or possibly pregnant (if yes confirm negative pregnancy test)..	☐	☐

Do you have any if these?	**YES**	**NO**		**YES**	**NO**
Pacemaker, wires, or defibrillator...........	☐	☐	Eyelid or Body Tattoo	☐	☐
Aneurysm Clips	☐	☐	Piercings..	☐	☐
Ear implant (cochlear)/ hearing aid........	☐	☐	Implanted catheter, tube, or shunt	☐	☐
Electrical stimulator for nerves or bone..	☐	☐	Artificial heart valve	☐	☐
Bullets, BBs, or pellets...........................	☐	☐	Penile prosthesis..................................	☐	☐
Metal Shrapnel or Fragments.................	☐	☐	False teeth, retainers, or braces	☐	☐
Infusion pump	☐	☐	Magnetic implant anywhere................	☐	☐
Coil, filter, wire, or stent in blood vessel.	☐	☐	Diaphragm or intrauterine device........	☐	☐
Orthopedic (plates, screws, pins, rods, wires, etc)..	☐	☐	Surgical clips, staples, wires, or sutures	☐	☐
Artificial Limb or joint	☐	☐	Dermal patches of any kind	☐	☐
Eye implant	☐	☐	Diabetic Neuropathy..............................	☐	☐

Answer the questions below if the participant is receiving gadolinium.
Please consult the IRB protocol associated with this project for guidelines related to the use of gadolinium

History of renal insufficiency.................	☐	☐	Are you on kidney dialysis.....................	☐	☐
History of diabetes.................................	☐	☐	History of paraproteinemia syndrome.	☐	☐
History of vascular disease.....................	☐	☐	History of hypertension........................	☐	☐
History of kidney disease........................	☐	☐	Hepato renal syndrome	☐	☐
History of liver disease...........................	☐	☐	Breastfeeding	☐	☐
Had a kidney or liver transplant............	☐	☐	Age 70 and older	☐	☐
Acute kidney injury.................................	☐	☐			

If you have answered yes to any of the above questions, please explain:

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SIGNATURE ______________________________ **DATE** ____________

MRI OPERATOR'S SIGNATURE ____________________