

**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?.....	<input type="checkbox"/>	<input type="checkbox"/>
Been a machinist, welder, metal worker or lathe operator?.....	<input type="checkbox"/>	<input type="checkbox"/>
Had an injury to your face or eye involving a piece of metal? (<i>metal shavings, slivers, bullets, BBs</i>).....	<input type="checkbox"/>	<input type="checkbox"/>
Had a MRI examination?	<input type="checkbox"/>	<input type="checkbox"/>

Are you:

Claustrophobic (do you have a fear of close places)?.....	<input type="checkbox"/>	<input type="checkbox"/>
Allergic to any medications?.....	<input type="checkbox"/>	<input type="checkbox"/>
Please list _____		
Pregnant or possibly pregnant (if yes confirm negative pregnancy test).....	<input type="checkbox"/>	<input type="checkbox"/>

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

**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.....	<input type="checkbox"/>	<input type="checkbox"/>	Are you on kidney dialysis.....	<input type="checkbox"/>	<input type="checkbox"/>
History of diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	History of paraproteinemia syndrome.	<input type="checkbox"/>	<input type="checkbox"/>
History of vascular disease.....	<input type="checkbox"/>	<input type="checkbox"/>	History of hypertension.....	<input type="checkbox"/>	<input type="checkbox"/>
History of kidney disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepato renal syndrome	<input type="checkbox"/>	<input type="checkbox"/>
History of liver disease.....	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
Had a kidney or liver transplant.....	<input type="checkbox"/>	<input type="checkbox"/>	Age 70 and older	<input type="checkbox"/>	<input type="checkbox"/>
Acute kidney injury.....	<input type="checkbox"/>	<input type="checkbox"/>	Medication Guidelines given by (initials) _____		

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

SIGNATURE _____ **DATE** _____

MRI OPERATOR'S _____