

Duke-UNC Brain Imaging and Analysis Center: MRI Safety Screening

All individuals entering the MRI suite must fill out this information to the best of their knowledge. Any potential contraindications must be reviewed with the individual's medical record and the BIAC MR Safety Committee before being cleared to enter the scanner bore.

Part I: For all individuals entering the scanner room

Name _____ Birthdate _____
Last name First name M.I.

Address _____ City _____

State _____ Zip Code _____ Phone (H)(____) _____ (W)(____) _____ (C)(____) _____

1. Have you ever had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, foreign body)? No Yes

If yes, please describe: _____

2. Have you ever worked with metal (grinding, fabricating, etc.)? No Yes

If yes, please describe: _____

3. Have you ever had surgery (including eye surgery)? No Yes

If yes, please describe: _____

4. Have you had any previous MRI studies or been in a MR scanner? No Yes

If yes, please list (most recent first): Body part _____ Date _____ Facility _____

If yes, did you have any problems? _____

Before you may enter the scanner room, you must remove all metallic objects.

- | | |
|--|--|
| <input type="checkbox"/> All contents of pockets, including back pockets | <input type="checkbox"/> Shoes that contain any metal (e.g., steel tipped) |
| <input type="checkbox"/> Wrist watch, any bracelets | <input type="checkbox"/> Hearing aids or other electronic devices |
| <input type="checkbox"/> Hair pins, clips, weaves, fasteners | <input type="checkbox"/> Pagers, cell phones, PDAs |
| <input type="checkbox"/> Pins or badges on shirt | <input type="checkbox"/> Dentures or removable retainer |
| <input type="checkbox"/> Belt with metal (e.g., buckle) | <input type="checkbox"/> Necklaces, chains |

Part II: For all individuals entering the scanner bore

1. Are you claustrophobic? No Yes

2. Do you have an IUD or diaphragm containing metal? No Yes

3. Are you pregnant, experiencing late menstrual period, or undergoing fertility treatment? No Yes

4. Do you currently have a fever or other acute illness? No Yes

5. Please list any surgeries or other invasive medical procedures in **as much detail as possible**:

Protocol: _____

Date: _____

6. Are you currently taking or have you recently taken any medication? No Yes

If yes, please list _____

7. Do you have anemia or any diseases that affect your blood? No Yes

If yes, please describe _____

8. Do you have a history of stroke, seizures, brain tumor, head trauma, or other neurological disorder? No Yes

If yes, please describe _____

9. Do you wear glasses or contact lenses? No Yes

If yes, please specify prescription (if known) _____

10. Do you have a breathing disorder (e.g., asthma, apnea), heart condition, or movement disorder? No Yes

Height _____ Weight _____ Handedness _____



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or on object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR magnet is **ALWAYS** on.

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



