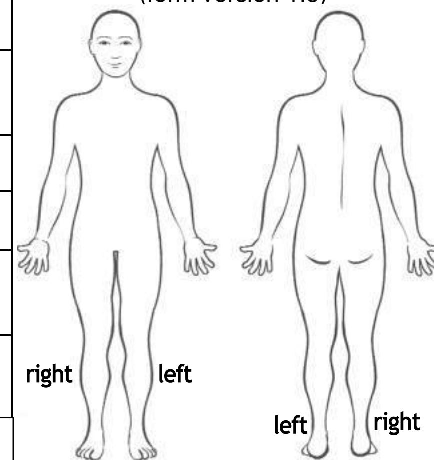
3T MRI PARTICIPANT SCREENING FORM

SDSU Imaging Center
Archive completed form at Center
(form version 1.6)

Principle Investigator / Lab:	StudyID - ***use format YYMMDDHHII****: hours in 24hr time* (e.g., 19062411MS)
Participant: (last name) (first name) (middle initial)	
Date of birth:	Weight:
Email:	
Mail Address: (number/street) (city) (zip code)	
Phone: (home) (work) (cell)	
Medications:	



Please answer each of the following questions, which are designed to find out if there is anything that could be hazardous to your safety or that might interfere with the MRI scan. If you check yes, give more information (e.g., type of material, how long ago). Use diagram to indicate approximate body location.

1. ▢ Yes ▢ No Do you have an implanted medical device? (e.g., heart pacemaker, cochlear implant, metal air tubes, TENS unit, bone stimulator, insulin or other medication pump, automatic defibrillator)
2. ▢ Yes ▢ No Is there a possibility of metal in your head? (e.g., aneurysm clips, CSF shunt, not dental fillings)
3. ▢ Yes ▢ No Is there a possibility of metal in your eyes? (have you needed an eyewash for metal work?)
4. ▢ Yes ▢ No Have you had any stents, clips, or surgery to any of your vessels (e.g. surgery on blocked arteries, carotid artery vascular clamp, coronary stent, aortic clips, IVS filter, coils to block arteries)
5. ▢ Yes ▢ No Have you had a permanent retainer, braces, or dental work?
6. ▢ Yes ▢ No Have you had any bone, tendon, spine, or joint surgery?
7. ▢ Yes ▢ No Do you suffer from claustrophobia or do you get uncomfortable in enclosed spaces (e.g., in an elevator)
8. ▢ Yes ▢ No Do you have any medical problems when you lie flat on your back? (breathing, back pain, nausea)
9. ▢ Yes ▢ No Do you have metal anywhere else in your body? (e.g., spinal rods, piercings, shrapnel, buckshot, bullets) – please indicate where on the diagram above
10. ▢ Yes ▢ No Do you have a tattoo(s), tattooed eyeliner, or tattooed eyebrows?
11. ▢ Yes ▢ No Have you had any medical condition that prevented you from completing an MRI exam in the past?
12. ▢ Yes ▢ No Are you suffering from asthma or do you have allergies to any medication you have taken recently?
13. ▢ Yes ▢ No Have you had any previous surgery? (mark location on your body the diagram above)
    Details:____Date(s): ________________________
14. ▢ Yes ▢ No Do you have a transdermal medicated patch? (e.g., nicotine, contraceptive, medicated pain relief)
15. ▢ Yes ▢ No Do you have any dry shampoo/conditioner or leave-on powdered hair dye in your hair?
16. ▢ Yes ▢ No Do you wear a hearing aid, dentures, hair extensions, wig, or colored contact lenses?
17. ▢ Yes ▢ No [female] Is there any possibility that you may be pregnant?
18. ▢ Yes ▢ No [female] Do you have an intrauterine device (IUD) containing copper?
19. ▢ Yes ▢ No Would you like to be informed if we notice something unusual in your brain scan?
20. [Initial]______ I acknowledge that these scans are *not* optimized for detection of clinical abnormalities.

Name of Participant/Subject (please print)	Signature	____/____/____ Date
Name of Operator (please print)	Signature	____/____/____ Date