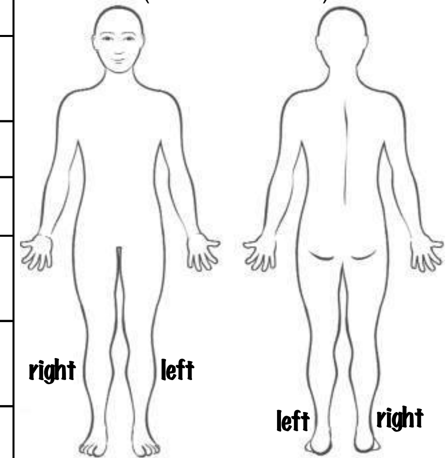
3T MRI PARTICIPANT SCREENING FORM

SDSU Imaging Center
Archive completed form at Center
(form version 1.0)

Principle Investigator / Lab:	Study ID *use format YYMMDDII:*
Participant: (last name) (first name) (middle initial)	
Date of birth:	Weight:
Email:	
Mail Address: (number/street) (city) (zip code)	
Phone: (home) (work) (cell)	
GP (name, address, phone):	



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 any metallic dental implants (e.g., 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 Do you suffer from claustrophobia or do you get uncomfortable in enclosed spaces (e.g., in a 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, dental work, 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 wear a hearing aid, or dentures, or a wig, or colored contact lenses? (tick "Yes" if any apply)

16. ☐ Yes ☐ No [female] Is there any possibility that you may be pregnant?

17. ☐ Yes ☐ No [female] Do you have an intrauterine device (IUD) containing copper?

18. ☐ Yes ☐ No May we contact your GP if we notice something unusual in your brain scan?

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 person completing form (please print) Signature Date

__________________________________ ________________________ ______/____/____
Name of safety personnel reviewing form Signature Date