UT Southwestern Advanced Imaging Research Center (AIRC)
MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR RESEARCH SUBJECTS

Date _____/_____/_____

Name ____ Age ________ Height ________ Weight _________

Last name First name Middle Initial

Date of Birth _____/_____/_____ ☐ Male ☐ Female Body Part to be Examined _____________________

month day year

Address ____ Telephone (home) (______) _______ - _______

City ____ Telephone (work) (______) _______ - _______

State ______________Zip Code______________________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ☐ No ☐ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery ____
   Date _____/_____/_____ Type of surgery ____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ☐ No ☐ Yes
   If yes, please list:

	Body part	Date	Facility
MRI	_______________	_______	______________________
CT/CAT Scan	_______________	_______	______________________
X-Ray	_______________	_______	______________________
Ultrasound	_______________	_______	______________________
Nuclear Medicine	_______________	_______	______________________
Other_________	_______________	_______	______________________

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe:____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
   If yes, please describe: ____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: ____
6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
   If yes, please list:____
7. Are you allergic to any medication? ☐ No ☐ Yes
   If yes, please list:____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes
   If yes, please list:____
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures? ☐ No ☐ Yes
   If yes, please describe: ____

For female patients:

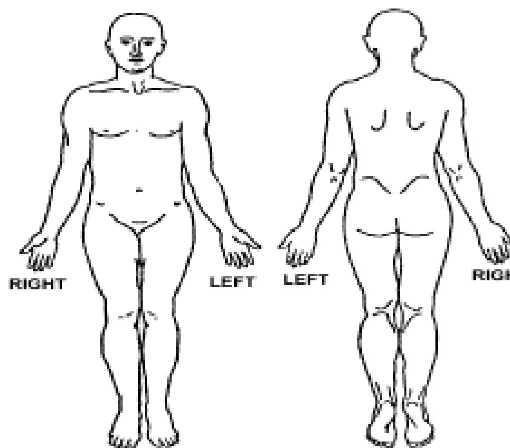
10. Date of last menstrual period: _____/_____/_____ Postmenopausal? ☐ No ☐ Yes
11. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
    If yes, please describe: ____
14. Are you currently breastfeeding? ☐ No ☐ Yes

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 question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

Do you have any of the following:

Aneurysm clip(s)	☐ No ☐ Yes
Implanted cardioverter defibrillator (ICD)	☐ No ☐ Yes
Cardiac pacemaker	☐ No ☐ Yes
Electronic implant or device	☐ No ☐ Yes
Magnetically-activated implant or device	☐ No ☐ Yes
Neurostimulation system	☐ No ☐ Yes
Spinal cord stimulator	☐ No ☐ Yes
Cochlear, otologic, or other ear implant	☐ No ☐ Yes
Bone growth/bone fusion stimulator	☐ No ☐ Yes
Internal electrodes or wires	☐ No ☐ Yes
Insulin or other infusion pump	☐ No ☐ Yes
Implanted drug infusion device	☐ No ☐ Yes
Any type of prosthesis (eye, penile, etc.)	☐ No ☐ Yes
Heart valve prosthesis	☐ No ☐ Yes
Eyelid spring or wire	☐ No ☐ Yes
Artificial or prosthetic limb	☐ No ☐ Yes
Metallic stent, filter, or coil	☐ No ☐ Yes
Shunt (spinal or intraventricular)	☐ No ☐ Yes
Radiation seeds or implants	☐ No ☐ Yes
Medication patch (Nicotine, nitroglycerine)	☐ No ☐ Yes
Any metallic fragment or foreign body	☐ No ☐ Yes
Wire mesh implant	☐ No ☐ Yes
Tissue expander (e.g., breast)	☐ No ☐ Yes
Surgical staples, clips, or metallic sutures	☐ No ☐ Yes
Joint replacement (hip, knee, etc.)	☐ No ☐ Yes
Bone/joint pin, screw, nail, wire, plate, etc.	☐ No ☐ Yes
IUD, diaphragm, or pessary	☐ No ☐ Yes
Dentures or partial plates	☐ No ☐ Yes
Tattoo or permanent makeup	☐ No ☐ Yes
Body piercing jewelry	☐ No ☐ Yes
Other implant ________________________	☐ No ☐ Yes
Hearing aid	☐ No ☐ Yes
(Remove before entering MR system room)	☐ No ☐ Yes
Breathing problem or motion disorder	☐ No ☐ Yes
Claustrophobia	☐ No ☐ Yes

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



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: ____ Date _____/_____/_____

Form Completed By: ☐ Patient ☐ Relative ☐ MR Tech___________________________________ ____________________
Print name Relationship to patient

Form Information Reviewed By: ____ ____________________
Print name Signature

☐ MRI Technologist ☐ Research Coordinator ☐ Level 2 Student/Post-doc ☐ Other____________________