Beth Israel Deaconess Medical Center **MRI Research Department**

MRI Research Safety & Study Information Form Updated 9/17/2020

Today's Date _____ Name _____ Subject ID _____

Your Weight _____ Date of Birth _____

Emergency Contact Name and Telephone Number_____

Have you signed a research consent form? ☐Yes ☐No

An MRI examination involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined *before* entering the exam room. Please place a check under the appropriate column for each of the items listed below.

Do you have any of the following? *(Documentation required on make and model of any implant)*	**Yes**	**No**
1. Do you have a pacemaker, pacer wires, implantable defibrillator, or implanted monitoring device? *If Yes:* Make/Model #: _____ Date of Surgery:_____		
2. Do you have any metallic heart valves or any stents (cardiac, carotid, renal, biliary, vascular, etc.)? *If Yes:* Make/Model #: _____ Date of Surgery:_____		
3. Do you have a Linx® Reflux Management System or EnteroMedics® VBLOC Maestro System?		
4. Do you have a bio or neurostimulator, spinal cord stimulator, or other neurological implant? *If Yes:* Make/Model #: _____ Date of Surgery:_____		
5. Do you have any aneurysm clips (ex. brain)? *If Yes:* Make/Model #: _____ Date of Surgery:_____		
6. Do you have any shunts (spinal, ventricular, peritoneal, subgaleal, etc.)? *If Yes:* Make/Model #: _____ Date of Surgery:_____ Are they programmable? □Yes □No		
7. Do you have an implanted pump (insulin, pain medicine, chemotherapy, etc.)?		
8. Are you wearing a patch that delivers medication (nicotine, nitroglycerin, pain medicine, etc.) or are you wearing a medicated cream?		
9. Have you had ear surgery, or an implant or prosthesis placed?		
10. Have you had eye surgery (cataracts, etc.), or an implant or prosthesis placed (eye springs or wire, etc.)?		
11. Are you currently wearing colored contact lenses or eye enlarger/dilator "circle lens"?		
12. Have you had a metal injury to the eye?		
13. Do you have shrapnel or any metal fragment including bullet fragments anywhere in your body?		
14. Do you have any weapons with you today (guns, bullets, knives)?		
15. Do you have an indwelling port, catheter, or feeding tube?		
16. Do you have any tissue expanders or implants (breast, chest wall, etc.)?		
17. Have you swallowed a core temperature sensor?		
18. Are you having an endoscopy study right now which uses a small pill camera?		
19. Have you had a colonoscopy, endoscopy, or interventional procedure in the last 30 days?		
20. In the last 30 days, have you had Feraheme® (ferumoxytol) iron fusion?		
21. Do you have you any type of prosthesis, external fixation device, artificial joints or pinning, or bone growth stimulators?		
22. Do you have permanent and/or removable dental work (braces, retainers, dentures, dental implants, etc.)?		
23. Do you have any body/skin piercings, body art modifications, tattoos, tattooed eyeliner, or permanent makeup? If yes, where: _____		
24. Are you wearing magnetic nail polish (Magna Nails™), magnetic eyelashes, or "Magic Hair"?		

	Yes	No
25. Is there a possibility that you are pregnant?		
26. Do you have an IUD (Intra Uterine Device)? *If Yes:* Make/Model #: _____		
27. Do you have a penile implant? *If Yes:* Make/Model #: _____		
28. Are you claustrophobic?		
29. Have you had an MRI before? If yes, when? _____		
30. Have you ever had any previous surgery? If yes, please list ALL surgeries since birth:		
31. Does this study you are having today involve contrast? (If so, please also fill out the Contrast Questionnaire.)		

Please circle if you have any of the following medical conditions:

Asthma	Hay-fever	Pheochromocytoma	Dubin-Johnson Syndrome

Important Instructions: The MRI staff will ask you to remove all personal items before entering the MRI environment or MRI rooms. Examples of items that MUST BE REMOVED are:

▪Keys ▪Watch ▪Pens	▪Body Piercings ▪Credit/ATM cards ▪Eye glasses	▪Hearing Aids ▪Wigs/Hair Pieces ▪Partial Plate	▪Barrettes ▪Bobby pins ▪Wallet	▪Safety pins ▪Cell phones ▪Pagers	▪Removable dental work ▪Clothing with metal fasteners/ metallic thread/ sequins or rhinestones

Patient Certification: I have answered these questions to the best of my ability. I understand that this information will be used to guide my care today.

X _____ _____ OR
Patient's signature Print Name

X _____ _____ and _____
Signature of Person Authorized to sign for patient Print Name Relationship to patient

Date: ___/___/___ Time: ___ ___ : ___ ___ ◯ a.m ◯ p.m.

X _____ _____ ___/___/___ ___ ___ ___ ___
Circle: M.D. / N.P. / P.A. / R.N. / Technologist - Signature Print Name Date Time (24 hour)

If you have an implant or surgery whose MRI safety needs to be further investigated, may we access your medical records?	☐Yes ☐No **Initial:** _____

ADMINISTRATIVE USE ONLY:

Study Name: _____

Scanner:	Pregnancy Test conducted?	Involves Contrast?	Subject Arrival Time	Room Entrance Time:	Room Exit Time:
1.5T / 3.0T / Other:	Yes / No (If yes: see Pregnancy test log for more information)	Yes / No (If yes: see contrast paperwork for more information)			