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

MRI Research Safety & Study Information Form

Updated 5/15/2021

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

Do you have any of the following? ***(Documentation required on make and model of any implant)*** **An MRI examination involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined entering the exam room. Please place a check under the appropriate column for each of the items listed below.**	**Yes**	**No**
1. Do you have an implanted pacemaker, pacer wires, or defibrillator? *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 or removable pump (insulin, pain medicine, chemotherapy, etc.)?		
8. Do you have an implanted or removable electronic monitoring device (glucose, cardiac, etc)		
9. Are you wearing a patch that delivers medication (nicotine, nitroglycerin, pain medicine, etc.) or are you wearing a medicated cream?		
10. Have you had ear surgery, or an implant or prosthesis placed?		
11. Have you had eye surgery (cataracts, etc.), or an implant or prosthesis placed (eye springs or wire, etc.)?		
12. Are you currently wearing colored contact lenses or eye enlarger/dilator "circle lens"?		
13. Have you had a metal injury to the eye?		
14. Do you have shrapnel or any metal fragment including bullet fragments anywhere in your body?		
15. Do you have any weapons with you today (guns, bullets, knives)?		
16. Do you have an indwelling port, catheter, or feeding tube?		
17. Do you have any tissue expanders or tissue implants (breast, chest wall, etc.)?		
18. Have you swallowed a core temperature sensor?		
19. Are you having an endoscopy study right now which uses a small pill camera?		
20. Have you had a colonoscopy, endoscopy, or interventional procedure in the last 30 days?		
21. In the last 30 days, have you had Feraheme® (ferumoxytol) iron fusion?		
22. Do you have any type of prosthesis, external fixation device, artificial joints or pinning, or bone growth stimulators?		
23. Do you have permanent and/or removable dental work (braces, retainers, dentures, dental implants, etc.)?		
24. Do you have any body/skin piercings, body art modifications, tattoos, tattooed eyeliner, or permanent makeup? If yes, where: ____________________________________		
25. Are you wearing magnetic nail polish (Magna Nails™), magnetic eyelashes, or "Magic Hair"?		

	Yes	No
26. Is there a possibility that you are pregnant?		
27. Do you have an IUD (Intra Uterine Device)? *If Yes:* Make/Model #: ________________________		
28. Do you have a penile implant? *If Yes:* Make/Model #: ________________________		
29. Are you claustrophobic?		
30. Have you had an MRI before? If yes, when? __________		
31. Have you ever had any previous surgery? If yes, please list ALL surgeries since birth:		
32. 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 ________________________________ _______
Name of Study Staff

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)			