

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? <i>If Yes: Make/Model #: _____ Date of Surgery: _____</i>		
2. Do you have any metallic heart valves or any stents (cardiac, carotid, renal, biliary, vascular, etc.)? <i>If Yes: Make/Model #: _____ Date of Surgery: _____</i>		
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? <i>If Yes: Make/Model #: _____ Date of Surgery: _____</i>		
5. Do you have any aneurysm clips (ex. brain)? <i>If Yes: Make/Model #: _____ Date of Surgery: _____</i>		
6. Do you have any shunts (spinal, ventricular, peritoneal, subgaleal, etc.)? <i>If Yes: Make/Model #: _____ Date of Surgery: _____</i> Are they programmable? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <i>If Yes: Make/Model #: _____</i>		
28. Do you have a penile implant? <i>If Yes: Make/Model #: _____</i>		
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
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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 | ▪Body Piercings | ▪Hearing Aids | ▪Barrettes | ▪Safety pins | ▪Removable dental work |
| ▪Watch | ▪Credit/ATM cards | ▪Wigs/Hair Pieces | ▪Bobby pins | ▪Cell phones | ▪Clothing with metal fasteners/ metallic thread/ sequins or rhinestones |
| ▪Pens | ▪Eye glasses | ▪Partial Plate | ▪Wallet | ▪Pagers | |

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)			