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.

<table>
<thead>
<tr>
<th>Do you have any of the following? (Documentation required on make and model of any implant)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| 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”? |
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:

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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
- Hearing Aids
- Wigs/Hair Pieces
- Barrettes
- Partial Plate
- Bobby pins
- Safety pins
- Wallet
- 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.

OR

Signature of Person Authorized to sign for patient  Print Name  Relationship to patient

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

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: __________

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ADMI NISTRATIVE USE ONLY:

Study Name: ____________________________

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Scanner: 1.5T   /   3.0T   /   Other:  

Pregnancy Test conducted?  

I Involve Contrast?  

Subject Arrival Time  

Room Entrance Time:  

Room Exit Time:  

Pregnancy test log for more information)  

Contrast paperwork for more information)