RUTGERS
UNIVERSITY

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM

To be completed by researcher:

Date: _____/_____/_____ Gender (circle one): Male Female Subject ID#: _____

Principal Investigator: _____ Researcher: _____
(First name - Middle Initial - Last name)

Study Title: _____

1. *Please indicate the following:*

Date of Birth (mm/dd/yy): _____/_____/_____ **Height** (feet' inches"): _____ **Weight** (lbs.): _____

Mark the box next to your answer for each question. *Response:*

2. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ Yes ☐ No
If YES, please describe: _____

3. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, etc.)? ☐ Yes ☐ No
If YES, please describe: _____

4. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ Yes ☐ No
If YES, please describe: _____

For FEMALE patients only: **5. Are you pregnant, or do you think you may be pregnant?** ☐ Yes ☐ No

The following items may be harmful to you in an MR setting or may interfere with image quality.
Please mark "yes" or "no" for every item as appropriate.

Yes	No		Yes	No	
☐	☐	Aneurysm clip(s)	☐	☐	Any metallic fragment or foreign body (e.g., shrapnel, metal filings, bullets)
☐	☐	Cardiac pacemaker	☐	☐	Wire mesh implant
☐	☐	Implanted cardioverter defibrillator (ICD)	☐	☐	Surgical staples, clips, or metallic sutures
☐	☐	Electronic implant or device	☐	☐	Bone/joint pin, screw, nail, wire, plate, etc.
☐	☐	Magnetically-activated implant or device	☐	☐	Metallic removable dental work, braces, retainers
☐	☐	Neurostimulation system	☐	☐	Tattoo or permanent makeup
☐	☐	Spinal cord stimulator	☐	☐	Body piercing jewelry (must be removed before scanning)
☐	☐	Internal electrodes or wires	☐	☐	Hearing aid (must be removed before scanning)
☐	☐	Bone growth/bone fusion stimulator	☐	☐	Claustrophobia
☐	☐	Cochlear, otologic, or other ear implant	☐	☐	Heart valve prosthesis
☐	☐	Insulin or other infusion pump or device	☐	☐	Joint replacement (hip, knee, etc.)
☐	☐	Any type of prosthesis (eye, penile, etc.)	☐	☐	IUD or diaphragm
☐	☐	Eyelid spring or wire	☐	☐	Underwire bra
☐	☐	Artificial or prosthetic limb	☐	☐	Other implant:_____
☐	☐	Metallic stent, filter, or coil			
☐	☐	Pins in Hair/Clothes/Hair Extensions/Wig			

Signature of Participant: _____ Date: _____/_____/_____

Printed Name (full): _____