Northeastern University
Biomedical Imaging Center

File Completed Form with NUBIC

3T MRI Pre-Entry Screening Form

Date of MRI: ____/____/_____

Name: _____

Date of Birth: ____/____/_____

Height: _____ Weight: _____ Gender: _____

FOR CENTER USE ONLY
PI/Lab: _____
Study Title: _____
IRB Protocol #: _____
Subject #: _____

1. Have you had an injury to the eye involving a metallic object or fragment (metallic slivers, foreign body, etc.)? ☐Yes ☐No
2. Do you have any metal fragments anywhere in your body (e.g., shrapnel, bullets or BB's)? ☐Yes ☐No
3. Have you recently had a small bowel procedure that required the ingestion of a "Pill Cam" capsule? ☐Yes ☐No
4. Have you had a colonoscopy or endoscopy that required the placement of any surgical clips or staples? ☐Yes ☐No
5. Have you ever had a prior surgical procedure of any kind? ☐Yes ☐No

   If yes, please indicate the type(s) of surgery and date(s):

   a. _____ c. _____

   b. _____ d. _____
6. Have you ever had an MRI? ☐Yes ☐No
7. Are you claustrophobic? ☐Yes ☐No
8. Do you have difficulty lying flat on your back? (breathing problems, back pain, nausea) ☐Yes ☐No
9. Do you have a breathing disorder, heart condition, or movement disorder? ☐Yes ☐No
10. Do you have a history of stroke, seizures, brain tumor, head trauma, or other neurological disorder? ☐Yes ☐No
11. Are you currently taking, or have you recently taken any medication? ☐Yes ☐No

    If yes, please list: _____
12. Are you allergic to any medication or drug? ☐Yes ☐No

    If yes, please list: _____
13. Do you wear glasses or contact lenses? ☐Yes ☐No
14. Are you currently wearing any clothing or compression wear that contains silver or copper threads (e.g., label indicating antimicrobial or Silverescent Technology, etc.)? ☐Yes ☐No

Female Participants:

15. Are you pregnant or suspect that you may be pregnant? ☐Yes ☐No
16. Do you have an IUD, diaphragm or pessary? ☐Yes ☐No

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Some of the following items may be hazardous to your safety or may interfere with the MRI exam. Please check the correct answer for each of the following.

Cardiac pacemaker, cardiac defibrillator (ICD), internal electrodes or pacing wires	☐Yes	☐No
Implantable loop recorder	☐Yes	☐No
Heart valve or any stents (cardiac, carotid, biliary, renal, vascular, etc.)	☐Yes	☐No
Aneurysm clips or embolization coils	☐Yes	☐No
Shunt (spinal or intraventricular)	☐Yes	☐No
Tissue expander (e.g., breast)	☐Yes	☐No
Penile implant	☐Yes	☐No
Spinal fusion	☐Yes	☐No
Clips, coils, staples, mesh or surgery to any of vessels (vascular clamp, aortic clips, hernia mesh etc.)	☐Yes	☐No
Blood clot filter (e.g., Greenfield, Bird's Nest etc.)	☐Yes	☐No
Implanted medical device/pump (insulin or other medication pump, powerport, bone stimulator etc.)	☐Yes	☐No
Joint replacement	☐Yes	☐No
Artificial or prosthetic limb	☐Yes	☐No
Eye surgery/implant (cataracts, eyelid spring, wire, etc.)	☐Yes	☐No
Inner ear surgery or implant (cochlear, stapes, etc.)	☐Yes	☐No
Hearing aid (**remove before entering MR room**)	☐Yes	☐No
Permanent or removable dental work (implants, dentures. partial plates, retainers, braces etc.)	☐Yes	☐No
Transdermal medicated patch (nicotine patch, contraceptive patch, pain relief patch, etc.)	☐Yes	☐No
Piercings, tattoos, tattooed eyeliner, permanent/semi-permanent cosmetics	☐Yes	☐No
Colored contact lenses or eye enlarger/dilator	☐Yes	☐No

IMPORTANT INSTRUCTIONS:

Before entering the MR environment, you must remove <u>all</u> metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, firearms, nail clipper, tools, and clothing with metallic threads.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo.

Signature of person completing form: _____ Date: ___/___/___

Printed name of person completing form: _____ ☐Participant ☐Relative

Signature of MRI scanner operator: _____ Date: ___/___/___

Printed name of MRI scanner operator: _____ Start Time: _____