



Center for Advanced Brain Imaging
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MAGNETIC RESONANCE SCREENING FORM

The MR suite contains a very strong magnet. Some metal objects can interfere with your scan or even be dangerous. Before you are allowed to enter, we must know if you have any metal in your body or have experienced any of the conditions listed below. Please answer the following:

	Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>		Metal fragments in your eyes	<input type="checkbox"/>	<input type="checkbox"/>	Tissue expander(Breast)
<input type="checkbox"/>	<input type="checkbox"/>		Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm clip
<input type="checkbox"/>	<input type="checkbox"/>		Any type of internal electrode(s) Pacing wires, Cochlear Implant, etc...	<input type="checkbox"/>	<input type="checkbox"/>	Implanted insulin pump
<input type="checkbox"/>	<input type="checkbox"/>		Swan-Ganz catheter	<input type="checkbox"/>	<input type="checkbox"/>	Halo vest or metallic cervical fixation device
<input type="checkbox"/>	<input type="checkbox"/>		Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Any type of intravascular coil, filter or stent
<input type="checkbox"/>	<input type="checkbox"/>		Implanted drug injection device	<input type="checkbox"/>	<input type="checkbox"/>	Any type of foreign body, shrapnel or bullet
<input type="checkbox"/>	<input type="checkbox"/>		Heart valve prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Any type of ear implant
<input type="checkbox"/>	<input type="checkbox"/>		Penile prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Any type of surgical clip or staple
<input type="checkbox"/>	<input type="checkbox"/>		Vascular access port	<input type="checkbox"/>	<input type="checkbox"/>	Intraventricular shunt
<input type="checkbox"/>	<input type="checkbox"/>		Artificial limb or joint	<input type="checkbox"/>	<input type="checkbox"/>	Dentures
<input type="checkbox"/>	<input type="checkbox"/>		Diaphragm (in place), IUD	<input type="checkbox"/>	<input type="checkbox"/>	Latex allergies
<input type="checkbox"/>	<input type="checkbox"/>		Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>	Wire mesh
<input type="checkbox"/>	<input type="checkbox"/>		Any type of electronic, mechanical or magnetic implant	<input type="checkbox"/>	<input type="checkbox"/>	Implanted cardiac defibrillator
<input type="checkbox"/>	<input type="checkbox"/>		Any implanted orthopedic items (e.g. pins, rods, screws, nails, clips, plates, wire, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	Medication patch
<input type="checkbox"/>	<input type="checkbox"/>		Tattoo or tattooed eyeliner	<input type="checkbox"/>	<input type="checkbox"/>	Amateur or prison tattoo
<input type="checkbox"/>	<input type="checkbox"/>		Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson
<input type="checkbox"/>	<input type="checkbox"/>		Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	Dementia



Warning: *Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do not enter the MR environment if you have any questions or concerns regarding an implant, device or object. Consult with the MR Technologist BEFORE entering the MR environment if you have any concerns. The MR system is ALWAYS on.*

Page 2: Magnetic Resonance Screening Form

<input type="checkbox"/> Yes	If you are female: Do you suspect that you are pregnant?
<input type="checkbox"/> No	
<input type="checkbox"/> N/A	
<input type="checkbox"/> Yes	Have you ever had surgery?
<input type="checkbox"/> No	
<input type="checkbox"/> Yes	If you have had surgery, were any metal, metallic, and/or medical devices implanted?
<input type="checkbox"/> No	
<input type="checkbox"/> Yes	Have you ever been injured by any metallic foreign body {e.g., bullet, BB, shrapnel, etc}?
<input type="checkbox"/> No	
<input type="checkbox"/> Yes	Have you ever had an eye injury involving a metal object, such as metallic slivers, shavings, foreign body, etc.?
<input type="checkbox"/> No	

BIRTHDATE, WEIGHT, HEIGHT

Date of Birth (MM/DD/YYYY)	Weight (Pounds)	Height (Feet, Inches)

IMPORTANT INSTRUCTIONS FOR YOUR SAFETY

Before entering the MR environment, you must remove all metallic objects including hearing aids, dentures, removable partial plates, keys, beeper, mobile phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paper clips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clipper, tools, shoes, clothing with metal fasteners (excluding pants & bra).

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 have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form:	Date (MM/DD/YYYY)

Form Completed By: Participant Relative

_____	_____
If relative, print your name	State your relationship to participant

For Office Use Only
Notes on any checked items:

For Experimenter Use Only:

Name of Project: _____
Principal Investigator: _____
Researcher(s): _____
Person obtaining screening: _____
Screening date & time: _____