Center for Cognitive and Behavioral Brain Imaging
The Ohio State University
225 Psychology Building 1835 Neil Avenue
Columbus, Ohio 43210 | 614-292-8911

MRI Screening Form

Important: this form should be completed carefully by/for all visitors and researchers who will enter the MRI suite. The following items may be extremely hazardous or cause poor image quality during the MRI scan. Please do not hesitate to ask for help in completing the list below.

Date _____/_____/_____ Subject Number _____
Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial
Date of Birth _____/_____/_____ Male Female
month day year
Address _____ Telephone (home) (_____) _____-_____
City _____ Telephone (work) (_____) _____-_____
State _____ Zip Code _____
Emergency Contact Name _____ _____Telephone (work) (_____) _____-_____
Referring Physician _____Telephone (work) (_____)_____-_____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? No Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _____
   Date _____/_____/_____ Type of surgery _____
2. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes
   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.)? No Yes
   If yes, please describe: _____
4. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes
   If yes, please describe: _____
5. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI examination? No Yes

For female patients:

6. Are you pregnant, possible pregnant or breastfeeding? No Yes

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Please indicate if you have any of the following:

Yes No Aneurysm clip(s)
Yes No Cardiac pacemaker
Yes No Implanted cardioverter defibrillator (ICD)
Yes No Electronic implant or device
Yes No Magnetically-activated implant or device
Yes No Neurostimulation system
Yes No Spinal cord stimulator
Yes No Internal electrodes or wires
Yes No Bone growth/bone fusion stimulator
Yes No Cochlear, otologic, or other ear implant
Yes No Insulin or other infusion pump
Yes No Implanted drug infusion device
Yes No Any type of prosthesis (eye, penile, etc.)
Yes No Heart valve prosthesis
Yes No Eyelid spring or wire
Yes No Artificial or prosthetic limb
Yes No Metallic stent, filter, or coil
Yes No Shunt (spinal or intraventricular)
Yes No Vascular access port and/or catheter
Yes No Radiation seeds or implants

Yes No Swan-Ganz or thermodilution catheter
Yes No Medication patch (Nicotine, Nitroglycerine)
Yes No Any metallic fragment or foreign body
Yes No Surgical staples, clips, or metallic sutures
Yes No Joint replacement (hip, knee, etc.)
Yes No Bone/joint pin, screw, nail, wire, plate, etc.
Yes No IUD, diaphragm, or pessary

Yes No Dentures or partial plates
Yes No Tattoo or permanent makeup
Yes No Body piercing jewelry
Yes No Hearing aid
Yes No Other implant _____
Yes No Breathing problem or motion disorder
Yes No Claustrophobia

Before entering the MR environment or MR system room, you must remove all 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, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or center staff if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I (please give full name in CAPITALS)_____ attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. I understand that I may withdraw from the study at any time if I feel uncomfortable.

Form Completed By:_____Date_____/_____/_____
Print name Signature Month Day Year
Form Information Reviewed By:_____ Date_____/_____/_____
Print name Signature Month Day Year