MAGNETIC RESONANCE IMAGING SCREENING FORM

Center for Cognitive and Behavioral Brain Imaging
The Ohio State University
1835 Neil Avenue
Columbus, Ohio 43210
Phone: 614-292-8911

For Office Use Only

ID No.:

Date _____ /_____ /_____ Is this your first time to be a participant in the Center? Yes No

Name _____,_____ Height _____ Weight _____ Male Female
Last name First name Middle Initial

Birthdate_____ /_____ /_____ Phone (H) (_____) _____-_____ (W) (_____) _____-_____

Mailing Address _____

Emergency Contact Name _____ Phone (_____) _____-_____

Primary Care Physician _____, _____ (_____) _____-_____
Name Address Phone

1. Have you ever had surgery or other invasive procedures? No Yes
   If yes, please specify type of surgery: _____
   If yes, is any metal object left in your body after the surgery? No Yes
2. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes
   If yes, please describe: _____
3. Have you ever been injured by a metallic object or fragment (e.g., BB, bullet, shrapnel, metallic slivers, shavings, etc.)? No Yes
   If yes, please describe: _____
4. Do you have a history of asthma, allergic reaction, or reaction to a contrast medium or dye used for an MRI examination? No Yes
5. Are you pregnant, possible pregnant or breast feeding? No Yes N/A

The MRI room 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 check the correct answer from each 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

Please remove **all metallic objects** before MR examination including: keys, hair pins, barrettes, jewelry, watch, safety-pins, paperclips money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material. Ear protection is required during the MRI examination.

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

Signature: _____ Date _____

Reviewed By:_____ Date _____