

3.0 T MRI RECRUITMENT / ADVANCED SCREENING FORM

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This form to be used for: Primary screening of research subjects being recruited by principal investigator (File completed form with PI)

Instructions for completing this form, and duplicate forms available from <http://cfmri.ucsd.edu/forms.html>

Principal investigator / Lab _____

Subject Weight _____ Subject Number _____

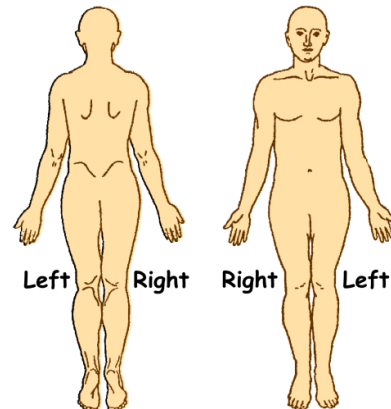
Name _____
Last name First name M.I.

Birthdate _____ Email Address _____

Address _____ City _____

State _____ Zip Code _____

Phone (_____) (_____) (_____)
Home Work Cell/Pager



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. If you checked yes, please give more information. E.g., Type of material? How long ago? Use the diagram to indicate where on your body?

1. Yes No Do you have a heart pacemaker?
2. Yes No Is there a possibility of metal in your head? (e.g. aneurysm clips, do not include dental work)
3. Yes No Is there a possibility of metal in your eyes or have you ever needed an eyewash having worked with metals?
4. Yes No Do you have an implanted medical device? (cochlear implant, metal ear tubes, tens unit, bone stimulator, insulin or other medication pump, automatic defibrillator, internal pacing wires).
5. Yes No Have you had any metallic dental implants (posts, crowns) within the last 6 weeks?
6. Yes No Have you had any bone, tendon, spine or joint surgery within the last 6 weeks?
7. Yes No *[Research subjects only:]* Do you weigh more than 300 lbs (135 kg)?

8. Yes No Is there any possibility that you may be pregnant?
9. Yes No Do you suffer with claustrophobia?
10. Yes No Do you have any medical problems when you lie flat on your back? (breathing problems, back pain, nausea)
11. Yes No Do you have an IUD that may contain copper, or a contraceptive diaphragm?
12. Yes No Have you had any stents, clips or surgery to any of any of your vessels (carotid artery vascular clamp, coronary stent, aortic clips, IVC filter, coils for blocked arteries)
13. Yes No Do you have metal anywhere else in your body? (spinal rods, dental work, piercings, shrapnel, buckshot, bullets) – please indicate where on your body using the diagram above
14. Yes No Do you have any piercings that can't be removed?
15. Yes No Do you have a cerebrospinal fluid (CSF) shunt? (treatment for hydrocephalus or water on the brain)
16. Yes No Do you have tattooed eyeliner, tattooed eyebrows or Bigen hair dye?
17. Yes No Have you had any previous surgery? (give details, and indicate where on your body using the diagram above)
Details: _____ Date: ____ / ____ / ____
Details: _____ Date: ____ / ____ / ____
18. Yes No Have you had any medical condition that has prevented you from completing an MRI exam in the past?
19. Yes No *[If medications or other substances are administered:]* Do you suffer with asthma or allergies to any medication?
20. Yes No Do you have a transdermal medicated patch? (nicotine patch, contraceptive patch, medicated pain relief patch)
21. Yes No Do you wear a hearing aid or dentures?
22. Yes No Are you wearing athletic clothing or compression garments with “silver-technology” or marketed as antimicrobial (e.g., Lululemon, Athleta, Columbia “Omniheat”, Under Armour, Tommy Copper, Juzo USA)?
23. Yes No Are you wearing magnetic eyeliner, mascara, or false eyelashes?

Name of person completing form (please print)

Signature

____ / ____ / ____
Date

Name of CFMRI safety personnel reviewing form (if secondary review needed)

Signature

____ / ____ / ____
Date