

RESEARCH 3.0T MR PRE - PROCEDURE PARTICIPANT SCREENING FORM

Participant ID# _____

fMRI Project Study # _____

Date _____ / _____ / _____ DD/MM/YYYY

Rotman Research Institute
Baycrest Health Sciences
3560 Bathurst Street, BB17, Toronto, ON M6A 2E1
Phone: (416) 785-2500 Ext. 3320, Fax: (416) 785-4299

Name _____ Height _____ cm Weight _____ Kg
Last Name First Name

Telephone#(_____) _____ Birth Date _____ / _____ / _____ DD/MM/YYYY

1. Have you ever worked as a machinist, metalworker, or in any profession or hobby grinding metal? Yes No
2. Have you ever had an injury to the eye involving a metallic object (e.g. metallic slivers, shavings, or foreign body)? Yes No
3. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, Buckshot, shrapnel, etc.)? Yes No
4. Are you pregnant, experiencing a late menstrual period, or having fertility treatments? (Post-Menopausal)? Yes No
5. Are you taking oral contraceptives or receiving hormonal treatment? Yes No
6. Are you currently taking or have recently taken any medication? Yes No Please List: _____
7. Do you have drug allergies or have you had an allergic reaction? Yes No Please List: _____

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer if you have any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No IUD, diaphragm, pessary or bladder ring |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip or brain clip | <input type="checkbox"/> Yes <input type="checkbox"/> No Facelift or other cosmetic surgery on body |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or ear implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Electrodes (on body, head, or brain) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal or wire mesh implants (<i>Retainers/Braces</i>) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulation System | <input type="checkbox"/> Yes <input type="checkbox"/> No Wire sutures or surgical staples, clips |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or other infusion pump | <input type="checkbox"/> Yes <input type="checkbox"/> No Harrington rods (spine) / metal rods in bones |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted drug infusion device | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacements (Knee, Hip etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone growth / bone fusion or spinal stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Carotid artery vascular clamp | <input type="checkbox"/> Yes <input type="checkbox"/> No Wig, toupee, or hair implants |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tissue expander (breast) | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal fragments (eye, head, ear, skin) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Prosthesis (eye/orbital spring or wire, penile, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma or breathing disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Magnetically- activated implant or device | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures or motion disorders |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial or prosthetic limb | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoos, permanent makeup |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other implants in body or head (radiation seeds) | <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Coloured</i> Contact Lenses(remove before scan Z4) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Internal electrodes or wires (pacing wires) | <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing(s) (remove before scan Z4) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Intravascular stents, filters, or coils | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aid (remove before scan Z4) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shunt (spinal or intraventricular) | <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures /partial plates (remove before scan Z4) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular access port and or catheters | <input type="checkbox"/> Yes <input type="checkbox"/> No Medication patch (remove before scan Z4) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Swan-Ganz or thermodilution catheter | <input type="checkbox"/> Yes <input type="checkbox"/> No Previous MRI Exam _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aortic clips | <input type="checkbox"/> Yes <input type="checkbox"/> No Other implants (List) _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Venous umbrella | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgeries (List) _____ |

Please remove **all metallic objects** prior to your MR examination including: keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, pocket knife, cell phone, partial plates, dentures, clothing with metallic threads i.e. antimicrobial / antibacterial underwear, etc.

You will be required to change for your MR examination. Non metallic, cotton attire will be provided. Earplugs and/or headphones are required during the MR examination to prevent possible problems or hazards related to acoustic noise.

I attest that the above information is correct to the best of my knowledge. I have read and I understand the contents of this form. I was given 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 _____ / _____ / _____

Form Completed By Participant Relative _____
Print Name Relationship to Participant

Form Information Reviewed By _____
Print Name Signature

MR Technologist _____ Level 11 Operator _____