

# MRI SAFETY SCREENING

UW Center for Human Neuroscience

Date (mm/dd/yyyy)	/ /	Lab:		MRI Operator:	
Name (first last)					
Birth Year (yyyy)		Height	ft.	in.	Weight lbs.



**WARNING:** The magnet of the MR system has a very **strong magnetic field** that is dangerous to a person entering the magnet room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. **The magnet is always on!**

Please answer the following about metallic and electrical objects in your body:

Have you had a prior surgery or operation?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Neuro stimulator?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you ever been injured by a metallic object?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cardiac pacemaker?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Electronic, mechanical, or magnetic implant?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Aneurism clip?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Intravascular stents, filters, or shunts?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing aid or dentures?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Permanent eye makeup or microblading?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Wig, weave, or hairpiece?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Metallic nail polish or magnetic eyelashes?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Retainer or braces?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sleep apnea stimulator (Inspire)?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Colored contact lenses?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Glucose monitor or transdermal medication patch?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have an IUD? (Paragard (copper) is NOT 3T compatible)			<input type="checkbox"/> No <input type="checkbox"/> Yes
Have you at any point in your life had a pacemaker, defibrillator, or neural stimulator?			<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have metal or electronic devices anywhere else in your body?			<input type="checkbox"/> No <input type="checkbox"/> Yes

**Pre-existing medical conditions:** Do you have a medical history of developing **seizures**, **ear infections/ear problems**, or currently suffering from **cold/flu symptoms**, **claustrophobic reactions**, or greater than normal potential for **anxiety** and/or cardiac arrest? Are you aware of any **brain anomalies**?

☐ No ☐ Yes

**Metallic objects:** Please **Remove all metallic objects** before entering the Magnet Room including hearing aids, cell phone, keys, eyeglasses, hair pins barrettes or clips, jewelry, body piercings, watch, wallet, coins, pens, hair bands, belts, metal underwire bras.

*Do not wear anti-microbial athletic clothing containing silver or metal threads.*



Metal  
Detector

Signature of Participant / Guardian

MRI Operator Signature

### To Be Completed By MRI Operator

Details of prior surgery or operation:

When was the surgery(s) performed? (note year or approximate year or within last six weeks)

Where there any metallic or other implants left in the participant's body?      Yes      No

If yes, what? (Indication location on drawing.)

Was this surgery reviewed by CHN staff prior to now?      Yes      No

CHN Staff safety determination?      Okay      Not-Okay      N/A

Other notes?

Okay to scan?      Yes      No

MRI Operator Initials: \_\_\_\_\_

