UC RIVERSIDE UNIVERSITY OF CALIFORNIA | Center for Advanced Neuroimaging

MRI Screening Form

Name/ID #(Print):		Phone:
DOB:	Height:	Weight:

Welcome to the UCR Center for Advanced Neuroimaging. Today you will be entering into a strong magnetic area. Before you are permitted to enter the facility, please answer the questions below. Please do not hesitate to ask our staff any questions that you may have.

		Yes	No
1	Do you have a pacemaker, cerebral arteriogram or stent?	☐	☐
2	Do you have an artificial heart valve or any metal implants related to the heart or blood vessel surgery?	☐	☐
3	Have you had surgery on your head or heart? If yes, what type? _____ _____	☐	☐
4	Do you have brain aneurysm clips?	☐	☐
5	Have you had eye surgery, implants, spring, wires, retinal tack?	☐	☐
6	Have you had ear surgery? If yes, what type? _____	☐	☐
7	Do you have cochlear implants, hearing aids, or stapes prosthesis?	☐	☐
8	Do you have any metal plates, pins, wires, screws, a joint replacement, or anything that might have been inserted during an operation/surgery? If yes, please describe: _____	☐	☐
9	Do you have any electronic devices inside or on your body?	☐	☐
10	Is there any chance you are pregnant (females only)?	☐	☐
11	Do you have an IUD? If so what type: _____ Results of Pregnancy Test	☐	☐
12	Is there any chance you have bullets, shrapnel or metal fragments in your body?	☐	☐
13	Have you done metal grinding, welding or other metal work?	☐	☐
14	Have you been injured in the eyes with metal fragments?	☐	☐
15	Do you have tattoos or permanent cosmetics?	☐	☐
16	Are you wearing a medication skin patch?	☐	☐
17	Are you claustrophobic (extreme fear of small spaces)?	☐	☐
18	Do you have metal mesh implants, wire sutures, wire staples, or clips?	☐	☐
19	Do you have an implanted drug infusion pump or insulin pump?	☐	☐
20	Do you have a vascular access port or catheter?	☐	☐
21	Do you have a neurostimulator?	☐	☐
22	Have you ever been told you can't have an MRI or fMRI for any reason? If yes, what was the reason?___	☐	☐

If you responded YES to any of the above questions, please STOP and submit this questionnaire to the researcher immediately.

23	Do you have removable dental work?		
24	Do you have dental bridges or dental plates? If yes, are they removable?		
25	Do you have metal dental caps? If yes, approximately how many?		
26	Do you have any non-removable metal in your mouth besides fillings?		
27	Do you have fillings? If yes, how many? _____		
28	Do you have an artificial limb? Is it removable?		
29	Do you have pins in your hair, hair extensions, hair pieces, or a wig?		
30	Are you wearing a hernia truss?		
31	Do you have epileptic seizures?		
32	Do you have hearing problems? If yes, do you have any of the following:		
	Hearing aid__ (If yes, removable__ non-removable__), cochlear implant__		
33	Are you wearing any cosmetics today?		
34	Do you have any piercings?		
35	Do you wear colored contacts? If yes, do you also have non-colored contacts?		
36	Are you being treated for heart rhythm problems?		

Printed name of participant or guardian: _____

Signature of participant or guardian: _____

Date: _____

Signature of CAN staff: _____