Safety Screening Form for participants in MRI Studies

Magnetic Resonance Imaging (MRI) is completely non-invasive. It can be relatively noisy, so you will be provided with hearing protection. MRI uses a strong magnetic field and radio waves. To preclude any risk of adverse effects or injury, please complete this form and hand it to the MRI scanner operator BEFORE ENTERING THE MRI ROOM. You will also need to remove all metallic objects, for example hearing aids, dentures, hair pins, jewelry and body piercing jewelry, keys, mobile phone, spectacles, watch, wallet, and clothing with metal fasteners.

LAST NAME :	**First Name** :		Sex : ☐ Male ☐ Female ☐ Other
Date of birth :	Height : cm	Weight : kg	

Have you had an **MRI scan** before?	☐ **YES**	☐ **NO**
If yes, have there been any **problems** during or after the scan?	☐ **YES**	☐ **NO**
Do you have any **metallic objects** or fragments in your body?	☐ **YES**	☐ **NO**
Do you have an aneurism **clip or coil**?	☐ **YES**	☐ **NO**
Do you or could you have a metallic object or fragment **in the eye**?	☐ **YES**	☐ **NO**
Have you been exposed to **metallic fragments** in your occupation (metal industry, grinding, welding, etc.)?	☐ **YES**	☐ **NO**
Do you have a cardiac **pacemaker**, or implanted cardioverter **defibrillator** (ICD)?	☐ **YES**	☐ **NO**
Do you have an **insulin pump** or other **implanted drug infusion device**?	☐ **YES**	☐ **NO**
Do you have a **cochlear** or other **ear implant**, a **neurostimulation system**, or any other **electronic or magnetically-activated implant or device**?	☐ **YES**	☐ **NO**
Do you have any internal **electrodes** or **wires**, a **vascular access port**, a **catheter**, or similar device in your body?	☐ **YES**	☐ **NO**
Do you have a **heart valve prosthesis**, artificial or prosthetic limb, **metallic stent or filter**? Do you have a **joint replacement**, **bone plate**, **screw**, **nail**, or **wire**?	☐ **YES**	☐ **NO**
Do you have any other kind of **implant**?	☐ **YES**	☐ **NO**
Have you had any **surgery** within the past six weeks?	☐ **YES**	☐ **NO**
Do you have an **intrauterine device (IUD)**, **diaphragm**, or **pessary**?	☐ **YES**	☐ **NO**
Is it possible that you may be **pregnant**?	☐ **YES**	☐ **NO**
Do you suffer from **claustrophobia**?	☐ **YES**	☐ **NO**
Can you lie on your back for prolonged periods without problems?	☐ **YES**	☐ **NO**
Do you have a **hearing aid**, **dentures** or **partial plates**, **braces**, **metallic restraint wire**?	☐ **YES**	☐ **NO**
Do you have a medication **patch** (for example nicotine, nitroglycerine)?	☐ **YES**	☐ **NO**
Do you have any **tattoos** or **permanent make-up**, or any body **piercing** jewelry?	☐ **YES**	☐ **NO**

Date :	Participant's signature :

☐ Approved ☐ Refused	Date :	Operator's signature :