

High Field Magnetic Resonance Imaging Center

Research MRI Suite, Basement Floor of Building 203
SFVAMC 4150 Clement Street, San Francisco, CA 94121



Pre-MRI Screening Form

Date: _____ / _____ / _____

Veteran Non-Veteran

Name: _____
Last Name First Name M.I.

Height: _____ Weight: _____

Birth Date: _____ / _____ / _____ Sex: Male Female

Social Security #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Physician's Name and Location: _____

Emergency Contact – Name: _____ Phone: (_____) _____

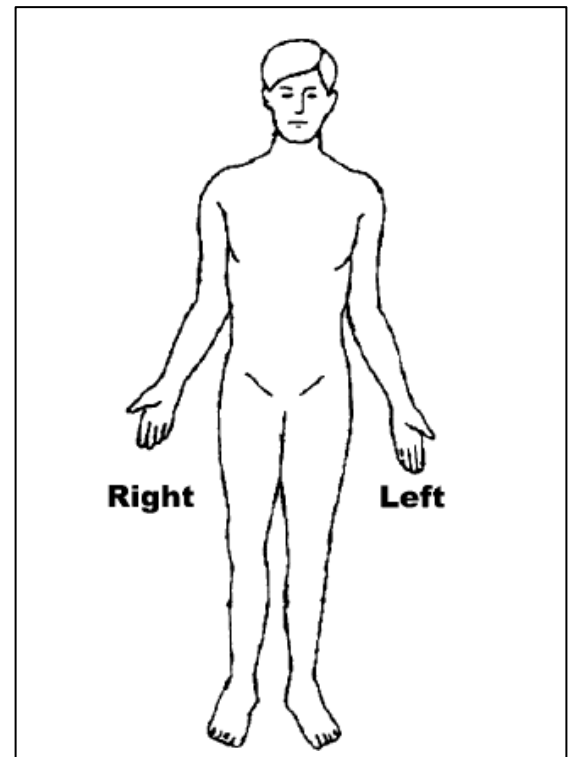
Please check each of the following:

- Yes No Previous MRI scan
- Yes No Cardiac pacemaker / defibrillator
- Yes No Aneurysm or aortic clip(s)
- Yes No Carotid artery vascular clamp
- Yes No Neurostimulator
- Yes No Insulin or infusion pump
- Yes No Bone growth / fusion stimulator
- Yes No Cochlear, otologic, or ear implant
- Yes No Prosthesis or implant (eye, heart valve, etc.)
- Yes No Artificial limb or joint
- Yes No Electrodes (on body, head, or brain)
- Yes No Stents, filters, or coils (intravascular)
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and / or catheter
- Yes No Tattooed makeup (eyeliner, lips, etc.)
- Yes No Body piercing(s) (**Remove before MRI**)
- Yes No Any metal fragments or shrapnel
- Yes No Bullets or bullet fragments
- Yes No Internal pacing wires
- Yes No Metal or wire mesh implants
- Yes No Wire sutures of surgical staples
- Yes No Harrington rods (spine)
- Yes No Bone / joint pin, screw nail, wire, plate
- Yes No Breathing disorder
- Yes No Claustrophobia
- Yes No Ligature or hemostatic clips
- Yes No Percutaneous ostomy device
- Yes No Hearing aid (**Remove before MRI**)
- Yes No Dentures (**Remove before MRI**)
- Yes No Nicotine patches (**Remove before MRI**)
- Yes No Other medication patches (**Remove before MRI**)
- Yes No Intrauterine Device (IUD)
- Yes No Are you pregnant

If answers below are yes, please explain:

- Yes No Worked extensively with metal (grinding, etc.)
- Yes No A history of seizures continuing to present

Please mark on the figure below the location of any implant or metal inside or on your body.



Remove all metallic objects prior to your MRI examination.

You are requested to wear earplugs during your MRI examination.

Explanation: _____

Veterans Affairs guidelines for Clinical Research require us to report ethnic and racial information for every person participating in a research study.

Please answer the following:

1. Are you Hispanic, Latino, or of Spanish Origin? Yes No

Please select one or more of the following:

1. Are you American Indian or Alaska Native? Yes No
2. Are you Asian? Yes No
3. Are you Native Hawaiian or Pacific Islander? Yes No
4. Are you Black or African American? Yes No
5. Are you White? Yes No

I prefer not to answer these questions.

Signature of participant or participant's representative

Form completed by: Subject Relative Physician or other: _____
Name and Relationship to subject

Signature of MR operator Date: ____/____/____