

WSU CoNNECT RESEARCHER SCREENING FORM

I attest that the information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. ANY CHANGES TO THIS FORM MUST BE REPORTED IMMEDIATELY

Date ____ / ____ / ____

Name _____

E-mail _____

Age _____ yrs Weight _____ lbs

Male Female

Principal Investigator/Supervisor _____ PI Phone # (____) ____ - _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? No Yes

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? No Yes

If yes, please list: Body part

MRI _____

CT/CAT Scan _____

X-Ray _____

Ultrasound _____

Nuclear Medicine _____

Other _____

3. Have you experienced any problem related to a previous MRI examination or MR procedure? No Yes

If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? No Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes

If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug? No Yes

If yes, please list: _____

7. Are you allergic to any medication? No Yes

If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No Yes

9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? No Yes

If yes, please describe: _____

For female patients:

10. Are you pregnant or experiencing a late menstrual period? No Yes

11. Are you taking oral contraceptives or receiving hormonal treatment? No Yes

12. Are you taking any type of fertility medication or having fertility treatments? No Yes

If yes, please describe: _____

13. Are you currently breastfeeding? No Yes

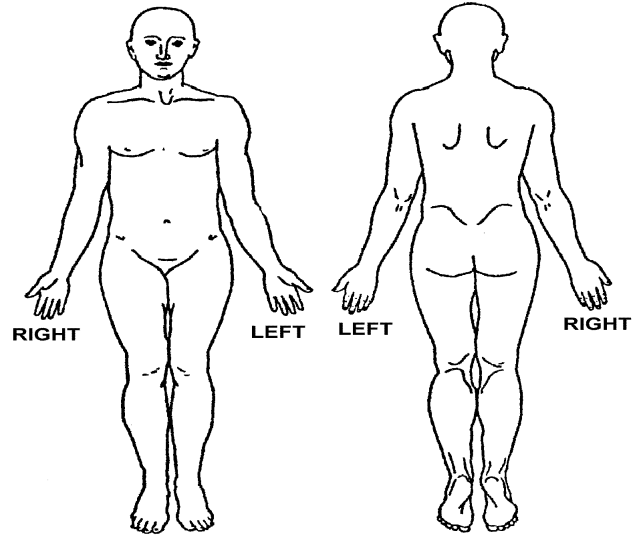


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Any metallic fragment or foreign body
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm, or pessary
If IUD, manufacturer: _____
- Yes No Are you here for an MRI examination?
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder

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



! IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Operator, Director or MR Scientist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

By signing this form, I attest that I have read all the materials including warnings of this form. I attest that the information provided is accurate. By submitting this form, I agree to abide by the rules and regulations set forth by Wright State University and the WSU Center of Neuroimaging and Neuro-Evaluation of Cognitive Technologies.

Signature of Person Completing Form: _____

Date: ____/____/____

Form Reviewed On ____/____/____

By: MR Scientist MR Operator Other _____

Print name

Signature

EXPIRES 1 YEAR FROM APPROVAL ON ____/____/____

Rev. 1.1, 11/14/2023