Subject Name:_____

For staff only:	
Session #:	**IRB #:**
Operator name and #	

BU Safety Screening Form

1. Do you have a problem with claustrophobia (fear of closed spaces?)
   No_____ A little _____ Pretty much _____ Severe _____

2. Do you have a heart pacemaker or defibrillator or other implanted devices? If yes, describe.
   No _____ Yes _____

3. Have you ever had an operation? If yes, Investigator to fill out Page 2.
   No _____ Yes _____

4. Have you ever been injured by metallic foreign body which was not removed?
   No _____ Yes _____

5. Do you wear braces on your teeth, or do you have false teeth or removable bridgework? Do you have any unremovable body piercings?
   No _____ Yes _____

6. Do you have any tatoos? If yes, describe their location.
   No _____ Yes _____

7. (Females only): Is there any possibility that you are pregnant?
   No _____ Yes _____

8. Please list medications you took today or are taking regularly.
   (try to include the name of the medicine, dose, how often, and time of last dose).

9. Have you ever had any previous studies (MRI, CT or other)? If yes circle on list.
   No _____ Yes _____
10. Do you have a breathing disorder or movement disorder? If yes describe.
    No _____ Yes _____

11. Weight: (lbs)_____ Birthdate:___/___/____

_____ Date: / /
Signature of Person Completing Page 1

Investigator to complete if Item #3 on Page 1 is Yes.

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

○ Yes ○ No	Cardiac pacemaker
○ Yes ○ No	Implanted cardiac defibrillator
○ Yes ○ No	Aneurysm clip(s)
○ Yes ○ No	Carotid artery vascular clamp
○ Yes ○ No	Neurostimulator
○ Yes ○ No	Insulin or infusion pump
○ Yes ○ No	Implanted drug infusion device
○ Yes ○ No	Bone growth/fusion stimulator
○ Yes ○ No	Cochlear, otologic, or ear implant
○ Yes ○ No	Any type of prosthesis (eye, penile, etc.)
○ Yes ○ No	Heart valve prosthesis
○ Yes ○ No	Artificial limb or joint
○ Yes ○ No	Electrodes (on body, head, or brain)
○ Yes ○ No	Intravascular stents, filters, or coils
○ Yes ○ No	Shunt (spinal or intraventricular)
○ Yes ○ No	Vascular access port and/or catheter
○ Yes ○ No	Swan-Ganz catheter
○ Yes ○ No	Any implant held in place by a magnet
○ Yes ○ No	Transdermal delivery system (Nitro)
○ Yes ○ No	IUD or diaphragm
○ Yes ○ No	Tattooed makeup (eyeliner, lips, etc)
○ Yes ○ No	Body piercing(s)
○ Yes ○ No	Any metal fragments
○ Yes ○ No	Internal pacing wires
○ Yes ○ No	Aortic clip
○ Yes ○ No	Metal or wire mesh implants
○ Yes ○ No	Wire sutures or surgical staples
○ Yes ○ No	Harrington rods (spine)
○ Yes ○ No	Metal rods in bones
○ Yes ○ No	Joint replacement _____
○ Yes ○ No	Bone/joint pin, screw, nail, wire, plate
○ Yes ○ No	Hearing aid ***(Remove before MRI)***
○ Yes ○ No	Dentures ***(Remove before MRI)***

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

---------- Date: / /

Signature of Investigator Completing Page 2