



**Center for Advanced Brain Imaging**  
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### MAGNETIC RESONANCE SCREENING FORM- Child Version

The MR suite contains a very strong magnet. Some metal objects can interfere with your child's scan or even be dangerous. Before your child is allowed to enter, we must know there are any metal objects in his/her body or whether he/she has experienced any of the conditions listed below. Please answer the following:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Metal fragments in your child's eyes	<input type="checkbox"/>	<input type="checkbox"/>	Tissue expander (Breast)
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm clip
<input type="checkbox"/>	<input type="checkbox"/>	Any type of internal electrode(s) Pacing wires, Cochlear Implant, etc...	<input type="checkbox"/>	<input type="checkbox"/>	Implanted insulin pump
<input type="checkbox"/>	<input type="checkbox"/>	Swan-Ganz catheter	<input type="checkbox"/>	<input type="checkbox"/>	Halo vest or metallic cervical fixation device
<input type="checkbox"/>	<input type="checkbox"/>	Hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	Any type of intravascular coil, filter or stent
<input type="checkbox"/>	<input type="checkbox"/>	Implanted drug injection device	<input type="checkbox"/>	<input type="checkbox"/>	Any type of foreign body, shrapnel or bullet
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Any type of ear implant
<input type="checkbox"/>	<input type="checkbox"/>	Penile prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Any type of surgical clip or staple
<input type="checkbox"/>	<input type="checkbox"/>	Vascular access port	<input type="checkbox"/>	<input type="checkbox"/>	Intraventricular shunt
<input type="checkbox"/>	<input type="checkbox"/>	Artificial limb or joint	<input type="checkbox"/>	<input type="checkbox"/>	Dentures or braces
<input type="checkbox"/>	<input type="checkbox"/>	Diaphragm (in place), IUD	<input type="checkbox"/>	<input type="checkbox"/>	Latex allergies
<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulator	<input type="checkbox"/>	<input type="checkbox"/>	Wire mesh
<input type="checkbox"/>	<input type="checkbox"/>	Any type of electronic, mechanical or magnetic implant	<input type="checkbox"/>	<input type="checkbox"/>	Implanted cardiac defibrillator
<input type="checkbox"/>	<input type="checkbox"/>	Any implanted orthopedic items (e.g. pins, rods, screws, nails, clips, plates, wire, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	Medication patch
<input type="checkbox"/>	<input type="checkbox"/>	Tattoo or tattooed makeup, such as eyeliner	<input type="checkbox"/>	<input type="checkbox"/>	Amateur or prison tattoo
<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizure



**WARNING:** *Certain implants, devices, or objects may be hazardous to your child during MR and/or may interfere with the MR procedure. Your child must not enter the MR environment until your questions and concerns regarding an implant, device or object are satisfied. Tell the MR Technologist BEFORE your child enters the MR environment if you have any concerns. The MR system is ALWAYS turned on, so please help us to be sure your child is safe.*

## Page 2: Magnetic Resonance Screening Form

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If your child is female: Do you suspect that she is pregnant?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever had surgery?
<input type="checkbox"/> Yes <input type="checkbox"/> No	If your child has had surgery, were any metal, metallic, and/or medical devices implanted?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever been injured by any metallic foreign body (e.g., bullet, BB, shrapnel, etc)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child ever had an eye injury involving a metal object, such as metallic slivers, shavings, foreign body, etc.?

## YOUR CHILD'S BIRTHDATE, WEIGHT, HEIGHT

Date of Birth (MM/DD/YYYY)	Weight (Pounds)	Height (Feet, Inches)

## IMPORTANT INSTRUCTIONS FOR YOUR SAFETY

***Before entering the MR environment, your child must remove all metallic objects including hearing aids, dentures, removable partial plates, keys, beeper, mobile phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paper clips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clipper, tools, shoes, clothing with metal fasteners (excluding pants & bra).***

**I attest that the above information about my child is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that my child is about to undergo.**

Signature of Legal Guardian Completing Form:	Date (MM/DD/YYYY)

\_\_\_\_\_

Print Your Name

\_\_\_\_\_

Print Child's Name

## For Office Use Only

Notes on any checked items:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## For Experimenter Use Only:

Name of Project: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_

Researcher(s): \_\_\_\_\_

Person obtaining screening: \_\_\_\_\_

Screening date & time: \_\_\_\_\_