

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. DO NOT ENTER the MR system room or MR environment if you have any questions or concerns 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.

PATIENT STICKER

Please indicate if you have any of the following:

- | | |
|---|---|
| <input type="checkbox"/> yes <input type="checkbox"/> no Aneurysm clips
<input type="checkbox"/> yes <input type="checkbox"/> no Cardiac pacemaker
<input type="checkbox"/> yes <input type="checkbox"/> no Implanted cardioverter defibrillator (ICD)
<input type="checkbox"/> yes <input type="checkbox"/> no Electronic Implant or device
<input type="checkbox"/> yes <input type="checkbox"/> no Magnetically-activated implant or device
<input type="checkbox"/> yes <input type="checkbox"/> no Neurostimulator system
<input type="checkbox"/> yes <input type="checkbox"/> no Spinal cord stimulator
<input type="checkbox"/> yes <input type="checkbox"/> no Internal electrodes or wires
<input type="checkbox"/> yes <input type="checkbox"/> no Bone growth/bone fusion stimulator
<input type="checkbox"/> yes <input type="checkbox"/> no Cochlear, otologic, or other ear implant
<input type="checkbox"/> yes <input type="checkbox"/> no Insulin or other infusion pump
<input type="checkbox"/> yes <input type="checkbox"/> no Implanted drug infusion device
<input type="checkbox"/> yes <input type="checkbox"/> no Any type of prosthesis (eye, penile, etc..)
<input type="checkbox"/> yes <input type="checkbox"/> no Heart valve prosthesis
<input type="checkbox"/> yes <input type="checkbox"/> no Eyelid spring or wire
<input type="checkbox"/> yes <input type="checkbox"/> no Artificial or prosthetic limb
<input type="checkbox"/> yes <input type="checkbox"/> no Metallic stent, filter, or coil
<input type="checkbox"/> yes <input type="checkbox"/> no Shunt (spinal or intraventricular) | <input type="checkbox"/> yes <input type="checkbox"/> no Radiation seeds or implants
<input type="checkbox"/> yes <input type="checkbox"/> no Swan-Ganz or thermodilution catheter
<input type="checkbox"/> yes <input type="checkbox"/> no Medication patch
<input type="checkbox"/> yes <input type="checkbox"/> no Metallic object or foreign body (eye or skin)
<input type="checkbox"/> yes <input type="checkbox"/> no Wire mesh implant
<input type="checkbox"/> yes <input type="checkbox"/> no Tissue expander (e.g., breast)
<input type="checkbox"/> yes <input type="checkbox"/> no Surgical staples, clips, metallic sutures
<input type="checkbox"/> yes <input type="checkbox"/> no Joint replacement (hip, knee, etc..)
<input type="checkbox"/> yes <input type="checkbox"/> no Bone/joint pin, screw, nail, wire, plate, etc.
<input type="checkbox"/> yes <input type="checkbox"/> no IUD, diaphragm, or pessary
<input type="checkbox"/> yes <input type="checkbox"/> no Dentures or partial plates
<input type="checkbox"/> yes <input type="checkbox"/> no Tattoo or permanent makeup
<input type="checkbox"/> yes <input type="checkbox"/> no Body piercing jewelry
<input type="checkbox"/> yes <input type="checkbox"/> no Hearing aid
<input type="checkbox"/> yes <input type="checkbox"/> no Other implant _____
<input type="checkbox"/> yes <input type="checkbox"/> no Vascular access port and/or catheter |
|---|---|

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, and clothing with metallic threads. PLEASE CONSULT THE MRI TECHNOLOGIST OR RADIOLOGIST BEFORE YOU ENTER THE MR SYSTEM ROOM

FOR FEMALE PARTICIPANTS:

- Date of last menstrual period ____/____/____ post menopausal? yes no
 Are you pregnant or experiencing a late menstrual period? yes no
 Are you taking oral contraceptives or receiving hormonal treatment? yes no
 Are you taking any type of fertility medication or having fertility treatments? yes no
 Are you currently breastfeeding? yes no

I attest that the above 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.

Patient Signature _____

Date _____

Technologist Signature _____