Beth Israel Deaconess Medical Center **MRI Research Department**

MRI Safety & Study Information Form Updated 4/1/11

Today's Date ____________ Name ____

Your Weight ____________ Date of Birth ____________ M/ F ______

Emergency Contact and telephone number____

Ethnicity: **This is for submission to our IRB to show diversity in our research studies.**					
	Latino OR Hispanic		Not Latino OR Hispanic		Decline to answer

Racial Background (please choose one). This is for submission to our IRB to show diversity in our research studies.					
	White		Black or African American		Asian
	Native Hawaiian or Other Pacific Islander		American Indian or Alaskan Native		Multiracial
	Unknown		Other		Decline to answer

An MRI examination involves the use of a very strong magnet. For your safety, the presence of certain metallic objects must be determined *before* entering the exam room. Please place a check under the appropriate column for each of the items listed below.

Devices or Metallic Objects ***(Documentation required on make and model of any implant)***	**Yes**	**No**
1. Pacemaker/Wires/Implantable Defibrillator		
2. Metallic Heart Valve Prosthesis		
3. Coronary Artery Bypass Graft Clips (CABG)		
4. Aneurysm Clips (Brain, Aorta, etc.)		
5. Intracranial Clips (brain surgery)		
6. Stents, Shunts, or Clips (e.g. gallbladder, breast, liver etc.)		
7. Middle Ear Prosthesis (surgery on bones in ear)		
8. Biostimulator, Neurostimulator, Brain stimulator, TENS device		
9. Implanted pump (insulin, pain medicine, chemotherapy, etc.)		
10. Limb or Joint Replacement or Pinning		
11. Shrapnel (anywhere in the body)		
12. Have you ever been a metal worker?		
13. Have you had an injury of metal to the eye?		
14. Surgery to the eye (implant)		
15. Are you wearing a patch that delivers medication?		
16. Are you claustrophobic?		
17. Have you ever had any previous surgery? If yes, please list ALL surgeries:		
19. Tissue expander (e.g., - breast implant)		
20. Do you have any Body Piercings that can not be removed? If yes, location (s):		
21. Are you having an endoscopy study right now in which you swallowed a small pill camera?		
Females	**Yes**	**No**
Is there a possibility that you might be pregnant?		
Do you have an IUD (Intra Uterine Device) or Diaphragm?		
Do you have a Pessary (in pelvis)?		
Males	**Yes**	**No**
Do you have a Penile Implant?		
Other	**Yes**	**No**
Did you sign the research consent form?		

Please Check all of the Following that apply to you:

Removable Dental Work (A cup will be provided)	Hearing Aids
Eyeglasses	Eye Make-up

It will be necessary for you to remove the following items:

Wigs or Hairpiece Watch Bobby pins Credit/ATM cards Keys Wallet/ Change Jewelry Phones/ Pagers

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Name:______________________________

IV Site__________ **Gauge**________
Tech ID__________

The Beth Israel Deaconess Medical Center
Contrast Allergy Questionnaire

	Yes	No
1. Have you had an MRI before? If yes, When? ___________		
2. Are you taking medication specifically for the MRI?		
3. Does this study you are having today involve contrast? (If so, please fill out the information below. If not, you can proceed to the bottom of the page and sign)		
4. Have you received an injection of contrast in the past for an MRI scan? If yes, When? ___________ (Per research policy, you cannot receive an MRI **contrast** injection less than 4 days from last MR contrast injection and a maximum of 10 contrast scans/ year, even if at another institution)		
5. Do you have a Hickman, Porta-Cath, or any other implanted port or indwelling catheter? (IV devices placed under the skin for access)		
6. Have you ever had trouble getting an IV put in?		
7. Do you have allergies to any foods or medications? Please List:		
8. Do you have Diabetes?		
9. Do you take either, Glucophage, Glucovance or Metformin for your diabetes?		
10. Are you on dialysis? If Yes, please indicate how often:		
Choyke Scale	**Yes**	**No**
1. Have you ever been told you have renal problems?		
2. Have you ever been told you have protein in your urine?		
3. Do you have high blood pressure?		
4. Do you have Gout?		
5. Have you ever had kidney surgery?		
6. Have you had a recent change in your health? E.g.: hospitalization or newly diagnosed problem? If yes, what happened and when did it happen?		
7. Are you currently taking the drug Hydroxyurea?		
Females	**Yes**	**No**
1. Are you taking Hormone Replacements?		
2. Are you breast feeding?		
3. Are you still menstruating? If so, when was your last menstrual period? ___________________________		

Please circle if you have any of the following medical conditions:

Asthma	Thyroid Disease	Kidney Disease	Pheochromocytoma	
Hay-fever	Heart Disease	Sickle Cell Disease	Multiple Myeloma	

Patient's Signature____

Relationship (if not the Patient) ______________________________________

Signature of Nurse / Technologist ______________________________________