CTI SAFETY FORM

WARNING!!!	MRI MACHINES USE A VERY STRONG **MAGNET** TO GENERATE IMAGES. CERTAIN IMPLANTS, DEVICES OR OBJECTS MAY BE **HAZARDOUS** TO YOU AND/OR MAY INTERFERE WITH THE MR PROCEDURE. **BEFORE** ENTERING THE MRI ROOM YOU MUST REMOVE ALL METALLIC OBJECTS, e.g. bobby pins, hairpieces, metallic skin patches etc. **WHEN IN DOUBT, PLEASE ASK MRI TECH!**

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

CARDIAC PACEMAKER	YES	NO	***ARE YOU PREGNANT***	YES	NO
IMPLANTED CARDIAC DEFIBRILLATOR (ICD)	YES	NO	***INJURED EYES WITH METAL FLAKES/SLIVERS/SHRAPNEL***	YES	NO
INTERNAL ELECTRODES/WIRES	YES	NO	***EYELID SPRING OR WIRE***	YES	NO
ARE YOU CLAUSTROPHOBIC	YES	NO	***MAGNETIC IMPLANTS***	YES	NO
COCHLEAR IMPLANTS	YES	NO	***ELECTRONIC DEVICE (DEEP BRAIN / SPINAL CORD / NERVE STIMULATOR)***	YES	NO
SWAN-GANZ OR THERMO-DILUTION CATHETERS	YES	NO			
IF YES ANSWERED TO ANY OF THE ITALICIZED BOLD PRINT QUESTIONS ABOVE SUBJECT IS NOT ELIGIBLE FOR MR					
BONE FUSION STIMULATOR	YES	NO	HEARING AID	YES	NO
TISSUE EXPANDER	YES	NO	TENS UNIT FOR PAIN	YES	NO
EYE SURGERY	YES	NO	RADIATION SEEDS OR	YES	NO
HEART VALVE PROSTHESIS	YES	NO	WIRE MESH IMPLANTS	YES	NO
SURGICAL STAPLES OR CLIPS	YES	NO	VASCULAR SURGERY	YES	NO
VASCULAR ACCESS PORT	YES	NO	IUD/DIAPHRAGM/PESSARY	YES	NO
SHUNTS AND/OR STENTS	YES	NO	TATOO/PERMANENT MAKEUP	YES	NO
BODY PIERCING JEWELRY	YES	NO	JOINT REPLACEMENT OR	YES	NO
ANEURYSM CLIP (S)	YES	NO	DENTURES OR PARTIALS	YES	NO
BONE/JOINT PIN, SCREWS, PLATE etc…	YES	NO	WORKED WITH METAL (e.g. WELDING/GRINDING)	YES	NO
INSULIN OR DRUG INFUSION DEVICE	YES	NO	a. ALWAYS WORN EYE PROTECTION?	YES	NO
EAR SURGERY	YES	NO	**(IF NO, RADIOGRAPHIC SCREENING REQUIRED!)**		
OTHER FOREIGN BODIES OR IMPLANTS	YES	NO	b. HAD AN EYE INJURY INVOLVING METAL?	YES	NO
HEAD SURGERY	YES	NO	c. WAS THE OBJECT REMOVED?	YES	NO
IF SUBJECT ANSWERED YES TO B) & NO TO C) ABOVE, RADIOGRAPHIC SCREENING REQUIRED (ORBITAL X-RAY/HEAD CT)					
MEDICATION OR NICOTINE PATCH	YES	NO	DO YOU HAVE KIDNEY DISEASE	YES	NO
DO YOU HAVE ASTHMA OR OTHER RESPIRATORY DISEASE	YES	NO	ARE YOU ALLERGIC TO ANY DRUGS, MRI OR CT CONTRAST	YES	NO
DO YOU HAVE SICKLE CELL ANEMIA	YES	NO	HAVE YOU EVER HAD AN ALLERGIC REACTION	YES	NO
ENTER DATE OF LAST MRI CONTRAST INJECTION					
COORDINATOR: ENTER DATE OF LAST MRI CONTRAST RECORD FROM EPIC (OR NONE IF NO RECORD FOUND)					

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE PLEASE EXPLAIN: ____________________

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SUBJECT NAME____________________ **SIGNATURE**____________________
(PLEASE PRINT)

BIRTHDATE (MM/DD/YYYY)__________ **WEIGHT**________ **HEIGHT**________ **DATE** __________

STUDY____________________ **COORDINATOR** ____________________
(MATCH CALENDAR NAME) **(PLEASE SIGN)**