UCONN | UNIVERSITY OF CONNECTICUT

BRAIN IMAGING RESEARCH CENTER

MRI SAFETY SCREENING FORM

Name:_____**Date of Birth**_____

Please read the following questions carefully. It is very important for us to know if you have any **metal devices** or **metal parts** anywhere in your body. If you do not understand a question, please ask us to explain! If you answer yes to any question, please contact the principal investigator.

1. Yes ☐ No☐ Do you have a heart pacemaker? (if you have a pacemaker, **you cannot have an MRI at BIRC**)
2. Yes ☐ No☐ Did you ever have a device implanted somewhere in your body like a heart defibrillator?
3. Yes ☐ No☐ Did you ever have an aneurysm clip implanted during brain surgery?
4. Yes ☐ No☐ Do you have a Carotid Artery Vascular clamp?
5. Yes ☐ No☐ Do you have nerve stimulators (neuron-stimulators also called TENS or wires)?
6. Yes ☐ No☐ Do you have any devices to make bones grow (like bone growth or bone fusion stimulators)?
7. Yes ☐ No☐ Do you have implants in your ear (like cochlear implants)?
8. Yes ☐ No☐ Do you have a Vagus nerve stimulator to help you with convulsions or with epilepsy?
9. Yes ☐ No☐ Do you have a filter for blood clots (Umbrella, Greenfield, bird's nest)?
10. Yes ☐ No☐ Do you have embolization coils (Gianturco) in your brain?
11. Yes ☐ No☐ Do you have implants in your eyes? Have you ever had cataract surgery?
12. Yes ☐ No☐ Do you have any stents (small metal tubes used to keep blood vessels open)?
13. Yes ☐ No☐ Do you have an implanted pump to deliver medication?
14. Yes ☐ No☐ Do you have an artificial arm or leg?
15. Yes ☐ No☐ Do you wear colored contact lenses?
16. Yes ☐ No☐ Do you wear a patch to deliver medicines through the skin?
17. Yes ☐ No☐ Do you have shrapnel or metal in your head, eyes or skin?
18. Yes ☐ No☐ Have you ever worked with metal? (For example in a machine shop, welding)
19. Yes ☐ No☐ Have you ever had metal removed from your eyes by a doctor?
20. Yes ☐ No☐ Have you ever had a gunshot wound? Or a B-B gun injury?
21. Yes ☐ No☐ Do you have body-piercing or jewelry on your body?
22. Yes ☐ No☐ Do you have permanent eye liner? (We need to make sure it does not heat up during the MRI)
23. Yes ☐ No☐ Do you use a hearing aid?
24. Yes ☐ No☐ Do you wear braces on your teeth or have a permanent retainer?
25. Yes ☐ No☐ Do you have a "shunt" (a tube to drain fluid) in your brain, spine or heart?
26. Yes ☐ No☐ Do you have metal joints, rods, plates, pins, screws, nails, or clips in any part of your body?
27. Yes ☐ No☐ Do you have a tattoo? (We need to make sure it does not heat up during the MRI)
28. Yes ☐ No☐ Do you get upset or anxious in small spaces?
29. Yes ☐ No☐ Have you ever had a CT or MRI before?
30. Yes ☐ No☐ Do you have asthma? Have you ever had an allergic reaction? If yes, to what? _____
31. Yes ☐ No☐ Have you ever had any surgery? Please list all _____
32. Yes ☐ No☐ Do you have hair extensions?
33. Yes ☐ No☐ Are you breastfeeding?
34. Yes ☐ No☐ Do you use a diaphragm, IUD, or cervical pessary? If IUD, what brand? _____
35. Yes ☐ No☐ Do you think there is any possibility that you might be pregnant? Date of last menstrual period _____
36. Yes ☐ No☐ Do you have a penile implant?

Weight _____ Height _____

Signature: _____ **Date:** _____

Reviewing technologist:_____**Date:**_____

Revised 06/12/2025