CTI SAFETY FORM

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.**

GFR VALUE > 60 _____ DATE _____

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 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
HOW MANY TIMES HAVE YOU HAD AN MRI WITH CONTRAST IN YOUR LIFETIME? SUBJECT WILL WRITE NUMBER					

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

_____

_____

_____

SUBJECT NAME _____ **SIGNATURE**_____
(PLEASE PRINT)

BIRTHDATE (MM/DD/YYYY)_____ **WEIGHT** _____ **HEIGHT** _____ **DATE** _____

STUDY_____ **COORDINATOR** _____
(MATCH CALENDAR NAME) **(PLEASE SIGN)**