Centre hospitalier universitaire vaudoise
Département de Radiologie

MRI SAFETY & SCREENING QUESTIONNAIRE

PARTICIPANT INFORMATION

Date (DD/MM/YYYY) _____ / _____ / _____

Time (24h; HH:MM) _____ : _____

Last name _____

First name _____

Weight (kg) _____

Height (m) _____

Body temp. (°C) _____

Date of Birth (DD/MM/YYYY) _____ / _____ / _____

Sex: ☐ Female ☐ Male

Handedness: ☐ Left ☐ Ambi-dextrous ☐ Right

ENSURING YOUR SAFETY DURING THE EXAM

The following items may be harmful to you during your MR scan or may interfere with the MR examination. Please provide a "yes" or "no" answer for every item.

YES	NO	
☐	☐	Cardiac pacemaker or implanted cardioverter defibrillator/ICD
☐	☐	Internal electrodes or wires (pacing wires, DBS or VNS wires)
☐	☐	Neurostimulator-TENS Unit, Biostimulator, bone growth stimulator, DBS, VNS
☐	☐	Ear (Cochlear) implant, middle ear implant
☐	☐	Artificial heart valve, coil, filter and/or stent (Gianturco coil, IVC filter)
☐	☐	Aneurysm clip(s)
☐	☐	Implanted drug pump (for chemotherapy medicine, pain medicine)
☐	☐	External drug pump (for Insulin or other medicine)
☐	☐	IV access port (Port-a-Cath, Broviac, PICC line, Swan-Gantz, Thermodilution)
☐	☐	Implanted post surgical hardware (pins, rods, screws, plates, wires)
☐	☐	Artificial joint and /or limb
☐	☐	Artificial eye and/or eyelid spring
☐	☐	Eye injury from a metal object (metal shavings, metal slivers)
☐	☐	Hearing aid(s) - **MUST BE REMOVED before entering room**
☐	☐	False teeth/dentures, metallic removable dental work, braces, retainers
☐	☐	Any type of implant held in place by a magnet
☐	☐	Injured by a metal object (shrapnel, bullet, BB) and required medical attention
☐	☐	Medication patch (nitroglycerine, nicotine, contraceptive, estrogen)
☐	☐	Shunt or Sophy adjustable and programmable pressure valve
☐	☐	Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator
☐	☐	Surgical clips, staples or surgical mesh
☐	☐	Tissue expander (breast)
☐	☐	Penile implant
☐	☐	Pessary, IUD, Diaphragm
☐	☐	Radiation seeds (cancer treatment)
☐	☐	Body piercing, tattoo or permanent makeup
☐	☐	Wig, hair implants
☐	☐	A RFID or radiofrequency ID device (e.g., wristband on an inpatient)

If you responded "YES" to any question above, MRI could be unsafe for you and you may not be eligible as a participant. For those items that are not immediate contraindications and that cannot be fully removed prior to the MRI scanning, the Radiology Coordinator will be consulted before proceeding. Please provide any further information that might be relevant to this final assessment:

Do you have a history of

YES	NO		YES	NO	
☐	☐	Claustrophobia	☐	☐	COVID-19
☐	☐	Diabetes	☐	☐	Kidney or liver disease
☐	☐	Asthma, respiratory disease, allergy, etc. Specify: _____			

Female participants

YES	NO	
☐	☐	Are you pre-menopausal? – If YES, date of last menstrual period: _____ / _____ / _____
☐	☐	Are you pregnant? – If YES, **you must not participate in the study anymore**
☐	☐	Are you experiencing a late menstrual period?
☐	☐	Is your period usually regular?
☐	☐	Are you taking oral contraceptives or receiving hormonal treatment?
☐	☐	Are you taking any type of fertility medication or having fertility treatments? If YES, please describe: _____
☐	☐	Are you currently breastfeeding?

PUNCTUAL CONSUMPTION OF SUBSTANCES THAT MAY ALTER BRAIN ACTIVITY

YES	NO		YES	NO	
☐	☐	Caffeine	☐	☐	Tobacco
☐	☐	Cannabis-derived substances	☐	☐	Painkillers
☐	☐	Tryptamine drugs	☐	☐	Opioids
☐	☐	Antidepressants	☐	☐	Anxiolytics
☐	☐	Stimulants	☐	☐	Antipsychotics
☐	☐	Mood stabilizers	☐	☐	Other (specify: _____)

If checked "YES" to any checkbox above, please indicate the number of hours before the session since the last intake:

Instructions for the participant:

1. Remove ALL jewelry and ALL body piercing jewelry and ALL hair accessories.
2. Remove dentures, false teeth, partial dental plates, and retainers.
3. Remove hearing aids and eyeglasses.
4. Remove ALL clothing and change into a hospital gown. Slippers will be provided.
5. Please use the restroom before your MRI exam.
6. Please make sure that you receive a pair of earplugs and/or headphones before your MRI exam begins. Some participants find the noise levels unacceptable.
7. Avoid close loops with your limbs (e.g., holding your hands together, crossing legs, etc.)

I, as the PARTICIPANT, attest the above information is correct to the best of my knowledge. I have read and understood the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

_____
Signature

_____
Printed Name

SIGNATURE OF PERSON ADMINISTERING SCREENING

I have reviewed all responses above, and all positive responses have been discussed, addressed, and reconciled if necessary.

_____ / / _____ :
Printed Name and Signature — Date (DD/MM/YYYY) Time (24h HH:MM)