



GSU/GT Center for Advanced Brain Imaging
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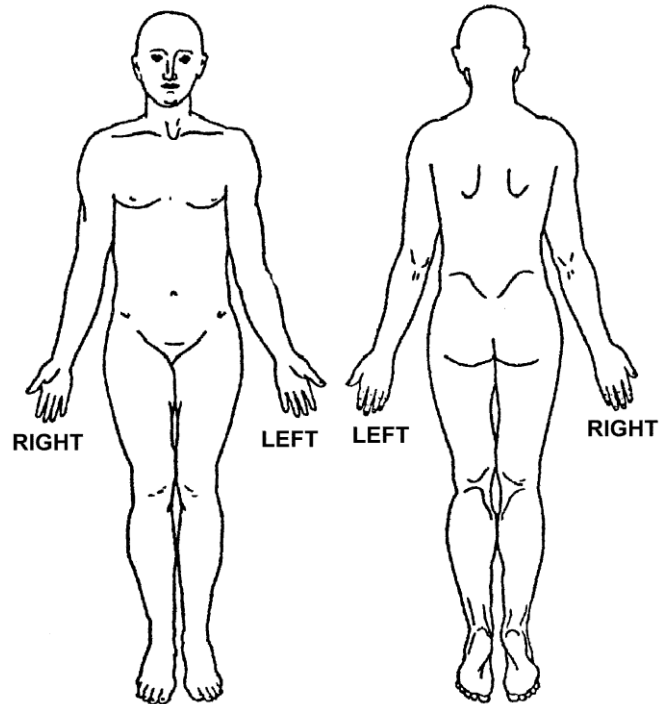
MAGNETIC RESONANCE SCREENING FORM- Child Version

The MR suite contains a very strong magnet. Some metal objects can interfere with your child's scan or even be dangerous. Before your child is allowed to enter, we must know if they have any metal objects in their body or have experienced any of the conditions listed below.

Please indicate if your child has any of the following:

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metal in skin, head or eyes |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy or history of seizure |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle cell anemia or blood disorder |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Parkinson/Dementia/Alzheimer's |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cardiac pacemaker |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart valve prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metallic stent, filter, or coil |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Vascular access port and/or catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electric or Mechanical implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetic implant or device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Aneurysm clip(s) or Spinal cord stimulator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt (spinal or intraventricular) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Wire mesh implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Insulin or other infusion pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Internal electrodes or wires |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation seeds or implants |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Swan-Ganz or thermodilution catheter |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgery |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical staples, clips, or metallic sutures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint replacement (hip, knee, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial or prosthetic limb |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bone growth/bone fusion stimulator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc.) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tissue expander (e.g., breast) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid spring or wire |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing aid |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear, otologic, or another ear implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medication patch (Nicotine, Nitroglycerine) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dentures, partial plates, or braces |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tattoo or permanent makeup/eyeliner |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Amateur or prison tattoo |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shrapnel, bullet, or metallic foreign body |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | IUD, diaphragm, or pessary |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pregnant or breastfeeding |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Jewelry that cannot be removed |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial cosmetic enhancements (hair extensions, magnetic eyelashes, nail polish etc.) |

Please mark on the figure(s) below the location of any implant or metal inside of or on your child's body.



Please consult the MRI Technologist if you have any questions or concerns BEFORE you enter the MRI scanner.

NOTE: Your child may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.



WARNING: Certain implants, devices, or objects may be hazardous to your child and/or may interfere with the MR procedure (i.e. MRI, functional MRI, MR spectroscopy). They should NOT enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE they enter the MR system room. The MR system magnet is ALWAYS ON.

IMPORTANT INSTRUCTIONS FOR YOUR SAFETY

Before entering the MR environment, your child must remove all metallic objects including hearing aids, dentures, removable partial plates, keys, beeper, mobile phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, watch, safety pins, paper clips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clipper, tools, shoes, clothing with metal fasteners (excluding pants & bra).

Name of Participant:

Date of Birth (MM/DD/YYYY)

Weight (Pounds)

Height (Feet, Inches)

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form:

Date (MM/DD/YYYY)

Form Completed by: Participant Relative

 If relative, print your name

 State your relationship to participant

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Notes on any checked items:

COINS Study Name: _____
Principal Investigator: _____
Researcher(s): _____
Person obtaining screening: _____
Screening date & time: _____