New York State Psychiatric Institute
Department of Psychiatry

MRI Metal Screening Questionnaire

Subject ID (NO NAMES PLEASE):	**Date of Birth:**
Screening Date:	**Important Medical Alerts:**
Weight:	

The following items may interfere with MR imaging. If you have any of the following please check either **Yes (Y)** or **No (N)** for each of them:

Y / N Are you presently working, or have you ever worked as a machinist, metal worker, or in any profession grinding metal?

Y / N Aortic clips, Venous umbrella	**Y / N** Do you have any history of Seizures or Epilepsy?
Y / N Heart valve, Stents	**Y / N** Claustrophobia
Y / N Aneurysm clips	**Y / N** Swallowing disorder
Y / N Metal implants in body or head	**Y / N** Breathing disorders
Y / N Shunt (spinal or ventricular)	**Y / N** Motion disorders
Y / N Biomedical implants, Bio-stimulation devices/ Patches	**Y / N** Non-removable body piercing
Y / N Cochlear implant in Ear	**Y / N** Dentures
Y / N Neurostimulator (Tens unit)	**Y / N** **E**lectrodes (on body, head, or brain)
Y / N Insulin pump	**Y / N** Metal mesh implant, metal rods
Y / N Shrapnel, buckshot, or bullets	**Y / N** Metal fragments removed from eyes
Y / N Bone or joint pins	**Y / N** Pregnancy / Date of LMP:_____
Y / N Tattoo / Permanent eyeliner	**Y / N** Hearing aid (remove for scan)
Y / N Cardiac pacemaker ,Internal pacing wires	
Signature of research personnel (screener)	**Signature of a Patient**

Y / N Presence of metal detected using hand-held scanner

If metal detected what were actions:

Signature of MRI Technologist	**Scan/Screen Date**