HCHS/SOL INCA MRI Ancillary Study (AS#2016.02)

Forms

NIA grant: Ancillary to HCHS/SOL: MRI Measures of Cerebrovascular Injury and AD Atrophy in a Study of Latinos (RF1 AG054548, C DeCarli & H Gonzalez)

English

CAC - Capacity Assessment Checklist
IRI - MRI Implant Required Information Form
MMA - Minor Adverse Event Form
MSE - Screening Enrollment Form
PMS - MRI Screening Form English
SAE - Serious Adverse Event Form
UPM - Unanticipated Problems Form

Spanish

PMS - MRI Screening Form Spanish

HCHS/SOL INCA MRI Capacity Assessment Checklist
CAC ver. 11/28/2017

ADMINISTRATIVE INFORMATION

Date of Consent: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyy)

Time: ☐☐:☐☐ am / pm Staff ID: ☐☐☐

Place PARTICIPANT information label here
Containing full name, HCHS ParticipantID

Instructions: *This paper form is to be administered to the participant in person after reading the IC, at the time of MRI visit. If participant is not able to consent, the alternate respondent (proxy) must complete Surrogate Maker form to complete Informed Consent for the participant.*

A. Consent Dialogue Name of *alternate respondent (proxy):* _____

1. Was protocol presented to/discussed with participant? No ☐ 1=Yes ☐ Other: _____
2. Was protocol presented to/discussed with participant's alternate respondent (proxy)?
   No ☐ Yes ☐ Other: _____

B. CONSENT ABILITIES

3. Did participant *make a choice* to participate in SOL INCA MRI study? No ☐ Yes ☐ Marginal ☐
   Choice: Participate ☐ Not Participate ☐ Defer Decision ☐ Decision Unclear ☐ Other ☐
   Briefly explain _____
4. Did participant show *understanding* of the research protocol and its elements, including risks/benefits of participation?
   No ☐ Yes ☐ Marginal ☐ Briefly explain _____
5. Did participant *show reasoning/provide rational reasons* for participation/non-participation in the research protocol? No ☐ Yes ☐ Marginal ☐ Briefly explain _____
6. Did participant show an *appreciation of the personal risks/benefits* of participation/non-participation in the research protocol? No ☐ Yes ☐ Marginal ☐ Briefly explain _____

C. CAPACITY /INFORMED CONSENT/ASSENT

7. Was participant competent to consent to participation/non-participation in research protocol?
   No ☐ Yes ☐ Other ☐ Briefly explain: _____
8. Was informed consent for research participation obtained from the participant?
   No ☐ Yes ☐ Other ☐ Briefly explain: _____
9. If participant unable to consent, was informed consent for research participation obtained from *alternate respondent (proxy)*? No ☐ Yes ☐ Other ☐ Briefly explain: _____
10. If participant unable to consent and *alternate respondent (proxy)* approved participation, did participant show ***assent*** to participation? No ☐ Yes ☐ N/A ☐ Unclear ☐ Other ☐ _____
    Briefly explain: _____

Completed by: _____ ***Date:*** ☐☐/☐☐/☐☐☐☐ *(mm/dd/yyy)*
[Signature]

Capacity Assessment Checklist © 2002 by Daniel Marson, JD, PhD, University of Alabama at Birmingham

HCHS/SOL INCA MRI
Implant Required Information Form
IRI ver. 1/19/2018

ADMINISTRATIVE INFORMATION

Date: ☐☐/☐☐/☐☐☐☐ Staff ID: ☐☐☐
(mm/dd/yyy)

Place PARTICIPANT information label here
Containing full name, HCHS ParticipantID
Site PI

***Instructions**: Participants with implants must be approved by the MRI safety officer before a MRI scan may be performed without exception. Provide required information on implants in this form*

Participant Information Required for MRI Safety Clearance

	Implant 1	Implant 2	Implant 3
1. Type of Implant:			
2. Location of Implant:			
3. Date of implantation:	☐☐/☐☐/☐☐☐☐	☐☐/☐☐/☐☐☐☐	☐☐/☐☐/☐☐☐☐
4. Manufacturer:			

_____/_____ Date: ☐☐/☐☐/☐☐☐☐
Signature/Printed name of Person Completing Form **Month Day Year**

HCHS/SOL INCA MRI Minor Adverse Event Form

ID NUMBER:									FORM CODE: MMA VERSION: 1, 6/21/2018	Contact Occasion:	0	1	SEQ #		

Administrative Information

0a. Completion Date: __ __ / __ __ / __ __ __ __ (m m / d d / y y y y) 0b. Staff ID: __ __ __

Instructions: *This form should be completed within 7 days of a minor adverse event. An event is minor if it DOES NOT affect a pregnant study participant, a fetus or a newborn, or if it DOES NOT result in any of the following outcomes: Death, A threat to life, Requires (inpatient) hospitalization, Likely causes persistent or significant disability or incapacity, Likely associated with a congenital anomaly or birth defect, Requires treatment to prevent one of the outcomes listed above, other than for pre-existing conditions detected as a result of participation in HCHS/SOL, its tests and examination protocol. Minor adverse events (MAEs) are anticipated and expected to occur as stated risks in the study protocol, whether study related or otherwise.*

A. EVENT INFORMATION – Completed at the HSCHS/SOL Field Center

1. Contract No.:
   HHSN ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
2. Principal Investigator: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
3. Field Center: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
4. Date MMA occurred: __ __ / __ __ / __ __ __ __ (m m / d d / y y y y)
5. Reported to:
   - Principal Investigator
     - No 0 ☐
     - Yes 1 ☐ date reported: __ __ / __ __ / __ __ __ __
   - Field Center IRB
     - No 0 ☐
     - Yes 1 ☐ date reported: __ __ / __ __ / __ __ __ __

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6. Source of the event:
   - Interview with study participant 1 ☐
   - Blood draw 2 ☐
   - Glucose load 3 ☐
   - Echocardiography scan 4 ☐
   - MRI Scan 5 ☐
   - Other physical examination or tests 6 ☐
   - Other 7 ☐
   - Specify: ________________________

7. Describe the event (*Enter in a notelog on DMS.)*

ID NUMBER:									FORM CODE: MMA VERSION: 1, 6/21/2018	Contact Occasion:	0	1	SEQ #		

8. Indicate whether the event is: Ongoing 1 ☐ Resolved 2 ☐

9. Describe what action was taken (*Enter in a notelog on DMS.)*

10. Is this type of event foreseen in the Informed Consent or study MOP?
No 0 ☐ Yes 1 ☐ (Go to End) Don't know 9 ☐

11. Likelihood of relationship to participation in HCHS/SOL:
Unrelated (clearly not related) 1 ☐
Unlikely (doubtful related) 2 ☐
Possible (may be related) 3 ☐
Probable (likely related) 4 ☐
Definite (clearly related) 5 ☐

B. ACTIONS TAKEN BY INVESTIGATORS - Completed by the HCHS/SOL Coordinating Center

12. Reported to: NHLBI ☐☐/☐☐/☐☐☐☐ OSMB ☐☐/☐☐/☐☐☐☐

13. Was a change to the protocol made because of this MMA?
No 0 ☐
Yes 1 ☐ If Yes, date changed: ☐☐/☐☐/☐☐☐☐

14. Were any other actions taken by the investigators in response to this MMA?
No 0 ☐
Yes 1 ☐ If Yes, date action taken: ☐☐/☐☐/☐☐☐☐

15. If yes to either of the above questions, please specify: _____

16. Completion Date: ☐☐/☐☐/☐☐☐☐ CSCC Staff ID: ☐☐☐

HCHS\SOL INCA MRI Screening and Enrollment Form
MSE

ID NUMBER:									FORM CODE: MSE VERSION: A 3/27/2019	Contact Occasion	0	1	SEQ #	0	1

Instructions: ***Complete*** *this form for all contacted participants. Complete section A at time of phone contact, and section B at time of MRI visit. Refer to QxQ for additional information.*

A. PHONE CONTACT

1. Contact Date (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐ 2. Staff ID: ☐☐☐

3. Phone Call Screening information? ☐
   0= Unable to contact for screening or enrollment [**End form, call back]**
   1= Yes, contacted participant and screened
   2= Callback, participant was contacted but screen not completed [**End form, call back]**
   3= Refused, screening not done **[End]**
   4= Moved out of area/country **[End]**
   5= Reported deceased **[End]**

A1. Call Pre-MRI –Screening

4. Pre-Screen completed? ☐ 0= No 1= Yes **[Go To 5]**
   4a. If No, reason ☐ 1= Need proxy **[***Schedule Call back,* **End]**
   ☐ 2= Medical information incomplete **[***Schedule Call back***, End]**
5. **Absolute** contraindication found in prescreening? ☐ 0= No 1= Yes **[Set Q7=1, End]**
6. **Possible** contraindication found in prescreening? ☐ 0= No 1= Yes **[***Follow protocol, confirm eligibility***]**

A2. Call Pre Screen Result

7. Enrollment Status in Ancillary Study ☐ 1= Ineligible **[End]**
   2= Eligible but refused to participate [**End]**
   3= Eligible and agreed to participate
8. MRI schedule Date ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

B. MRI Visit

B1. Informed Consent Tracking

9. Consented by: ☐ 1= Proxy 2= Participant 10. Consenting Staff ID: ☐☐☐
11. Consent date: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)
12. Consent/assent Status ☐ 0= Refused to participate [**End]** 1= Agreed to participate

B2. MRI Technician Review

13. MRI Technician screened participant? ☐ 0= No **[Go To 15]** 1= Yes
14. MRI eligibility approved by Technician? ☐ 0= No 1= Yes

B3. MRI Status

15. MRI exam was… ☐ 0= Not performed 1= Performed [**Go To 16**]
    15a. If not performed, Specify: _____[**END**]
16. MRI exam Date ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

HCHS/SOL INCA MRI Pre-MRI Screening Form

PMS ver. 5/9/2018 English

ADMINISTRATIVE INFORMATION

Date: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyy)

DOB: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyy) Staff ID: ☐☐☐

Height: _____ Weight: _____

Place PARTICIPANT information label here
Containing full name, HCHS ParticipantID
Site PI

***Instructions**: Participants with implants must be approved by the MRI safety officer before a MRI scan may be performed without exception.*

1. Have you ever had surgery or similar invasive procedure in which medical devices may have been implanted? No ☐ Yes ☐

   If yes, please list:

Type of surgery	Date (mm/dd/yyyy)
_____	☐☐/☐☐/☐☐☐☐
_____	☐☐/☐☐/☐☐☐☐

2. Have you had any previous MRI imaging studies? No ☐ Yes ☐

   If yes, please list:

Body Part	Date (mm/dd/yyyy)	Facility Location
_____	☐☐/☐☐/☐☐☐☐	_____
_____	☐☐/☐☐/☐☐☐☐	_____
_____	☐☐/☐☐/☐☐☐☐	_____

3. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, shrapnel, foreign body)? No ☐ Yes ☐

   If yes, please describe: _____

For female participants only:

4. Are you pregnant, or is there a possibility that you are pregnant? (if unsure, please notify MRI operator or Principal Investigator) No ☐ Yes ☐
5. Are you breastfeeding? No ☐ Yes ☐
6. Date of last menstrual period: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)
7. Are you taking any type of fertility medication or having fertility treatments? No ☐ Yes ☐
8. Are you taking oral contraceptives or receiving hormone treatment? No ☐ Yes ☐

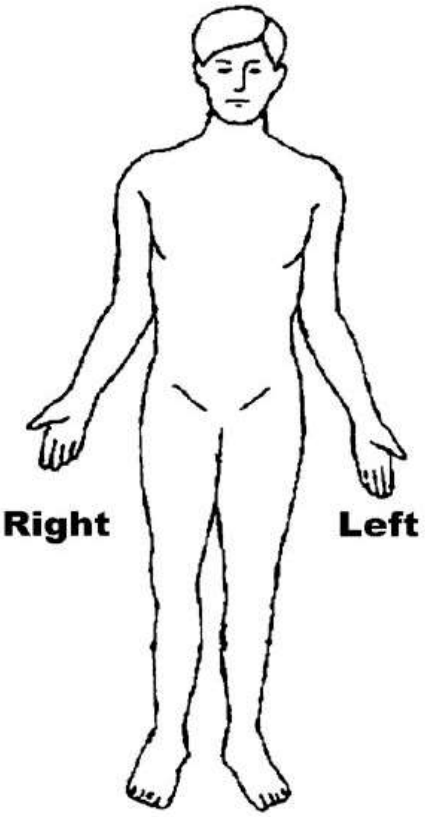
9. Do you have a history of seizure disorder or epilepsy? No ☐ Yes ☐

PARTICIPANTS WITH IMPLANTS MUST BE APPROVED BY THE MRI SAFETY OFFICER BEFORE A MRI SCAN MAY BE PERFORMED WITHOUT EXCEPTION.

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

Yes	No	Implant Location
☐	☐	Dental Hardware (e.g. metal crowns, braces, retainers)
☐	☐	Cardiac pacemaker
☐	☐	Implanted cardiac defibrillator
☐	☐	Aneurysm clip(s)
☐	☐	Carotid artery vascular clamp
☐	☐	Neurostimulator
☐	☐	Insulin or infusion pump
☐	☐	Implanted drug infusion device
☐	☐	Bone growth/fusion stimulator
☐	☐	Cochlear, otologic, or implant
☐	☐	Any type of prosthesis (eye, penile, etc.)
☐	☐	Heart valve prosthesis
☐	☐	Artificial limb or joint
☐	☐	Electrodes (on body, head, or brain)
☐	☐	Intravascular stents, filters, or coils
☐	☐	Shunt (spinal or intraventricular)
☐	☐	Vascular access port and/or catheter
☐	☐	Swan-Ganz catheter
☐	☐	Any implant held in place by a magnet
☐	☐	Transdermal Patch Delivery System (e.g. Nicotine,) (Remove before MRI)
☐	☐	IUD or diaphragm
☐	☐	Tattooed makeup (eyeliner, lips, etc.)
☐	☐	Body piercing(s) (Remove before MRI)
☐	☐	Any metal fragments (including bullets, shrapnel)
☐	☐	Internal pacing wires
☐	☐	Aortic clip
☐	☐	Metal or wire mesh implants
☐	☐	Wire sutures or surgical staples
☐	☐	Harrington rods (spine)
☐	☐	Metal rods in bones
☐	☐	Joint replacement: _____
☐	☐	Bone/joint in, screw, nail, wire, plate
☐	☐	Hearing aid (Remove before MRI)
☐	☐	Dentures (Remove before MRI)
☐	☐	Breathing disorder
☐	☐	Movement disorder
☐	☐	Claustrophobia
☐	☐	Anxiety
☐	☐	Other: _____

Please mark on the figure below, the location of any implant or metal inside of or on your body.



Before your MRI, please **remove all metallic objects** including keys, hairpins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocketknife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

_____ Date: ☐☐/☐☐/☐☐☐☐

Signature/Printed name of Person Completing Form **Month Day Year**

Form completed by: ☐ Participant ☐ Relative: _____

Name & relationship to participant

☐ Physician or other: _____

Name & relationship to participant

HCHS/SOL INCA MRI Serious Adverse Event Form

ID NUMBER:									FORM CODE: SAE VERSION: 1, 6/1/2018	Contact Occasion:	0	1	SEQ #	0	0

Administrative Information

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (m m / d d / y y y y)   0b. Staff ID: ☐☐☐

Instructions: *This form should be completed within 24 hours of an serious adverse event. An adverse event is serious if it affected a pregnant study participant, a fetus or a newborn, or if it results in any of the following outcomes: Death, A threat to life, Requires (inpatient) hospitalization, Likely causes persistent or significant disability or incapacity, Likely associated with a congenital anomaly or birth defect, Requires treatment to prevent one of the outcomes listed above, other than for pre-existing conditions detected as a result of participation in HCHS/SOL, its tests and examination protocol. Serious adverse events (SAEs) are therefore unanticipated and unexpected, whether study related or otherwise.*

A. EVENT INFORMATION – Completed at the HSCHS/SOL Field Center

1. Contract No.:
   HHSN ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. Principal Investigator: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3. Field Center: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. Date SAE occurred: ☐☐/☐☐/☐☐☐☐ (m m / d d / y y y y)

5. Reported to:

   Principal Investigator — No 0 ☐ ; Yes 1 ☐ date reported: ☐☐/☐☐/☐☐☐☐

   Field Center IRB — No 0 ☐ ; Yes 1 ☐ date reported: ☐☐/☐☐/☐☐☐☐

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6. Serious adverse episode affecting:
   - Pregnant study participant 1 ☐
   - Fetus 2 ☐
   - Neonate 3 ☐
   - Other 4 ☐
     Specify: ____________________

7. Category of the Serious Adverse Event
   - Death 1 ☐
   - Life-threatening 2 ☐
   - Requires hospitalization 3 ☐
   - Associated with disability / incapacity 4 ☐
   - Likely associated with congenital anomaly / birth defect 5 ☐
   - Required intervention to prevent permanent impairment 6 ☐
   - Other 7 ☐

     Specify: ________________________

8. Describe the event (*Enter in a notelog on DMS.)*

9. Indicate whether the event is: ☐ 1 Ongoing ☐ 2 Resolved

10. Describe what action was taken (*Enter in a notelog on DMS.)*

11. Likelihood of relationship to participation in HCHS/SOL:

Unrelated (clearly not related) 1 ☐
Unlikely (doubtful related) 2 ☐
Possible (may be related) 3 ☐
Probable (likely related) 4 ☐
Definite (clearly related) 5 ☐

B. ACTIONS TAKEN BY INVESTIGATORS - Completed by the HCHS/SOL Coordinating Center

12. Reported to: NHLBI ☐☐/☐☐/☐☐☐☐ OSMB ☐☐/☐☐/☐☐☐☐

13. Was a change to the protocol made because of this SAE?

No 0 ☐
Yes 1 ☐ If Yes, date changed: ☐☐/☐☐/☐☐☐☐

14. Were any other actions taken by the investigators in response to this SAE?

No 0 ☐
Yes 1 ☐ If Yes, date action taken: ☐☐/☐☐/☐☐☐☐

15. If yes to either of the above questions, please specify: _____

16. Completion Date: ☐☐/☐☐/☐☐☐☐ CSCC Staff ID: ☐☐☐

HCHS/SOL INCA MRI Unanticipated Problem Form

ID NUMBER:								FORM CODE: UPM VERSION: 1, 5/30/2018	Contact Occasion:	0	1	SEQ #		

Administrative Information

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (m m / d d / y y y y) 0b. Staff ID: ☐☐☐

Instructions: *This form should be completed within 48 hours of an Unanticipated Problem (UP). UPs include any experience or outcome that is unexpected, and related or possibly related to participation in SOL, and Suggestive that the research places subjects or others at a greater physical, psychological, economic, or social risk or harm than was previously known*

A. EVENT INFORMATION – Completed at the HSCHS/SOL Field Center

1. Contract No.:
   HHSN ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

2. Principal Investigator: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3. Field Center: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

4. Date UP occurred: ☐☐/☐☐/☐☐☐☐ (m m / d d / y y y y)

5. Reported to:

Principal Investigator	No	0 ☐	
	Yes	1 ☐	date reported: ☐☐/☐☐/☐☐☐☐
Field Center IRB	No	0 ☐	
	Yes	1 ☐	date reported: ☐☐/☐☐/☐☐☐☐

6. Source of the event:

Interview with study participant	1 ☐
Blood draw	2 ☐
Glucose load	3 ☐
Echocardiography scan	4 ☐
MRI Scan	5 ☐
Other physical examination or tests	6 ☐
Other	7 ☐

Specify: ________________________

7. Describe the event (limit to 250 words or less)

ID NUMBER:									FORM CODE: UPR VERSION: 1, 5/30/2018	Contact Occasion:	0	1	SEQ #		

Indicate whether the event is: Ongoing 1 ☐ Resolved 2 ☐

8. Describe what action was taken (limit to 250 words or less)

B. ACTIONS TAKEN - Completed by the HCHS/SOL Coordinating Center

9. Reported to: NHLBI ☐☐/☐☐/☐☐☐☐ OSMB ☐☐/☐☐/☐☐☐☐

10. Was a change to the protocol made because of this UP?

No 0 ☐

Yes 1 ☐ If Yes, date changed: ☐☐/☐☐/☐☐☐☐

11. Were any other actions taken by the investigators in response to this UP?

No 0 ☐

Yes 1 ☐ If Yes, date action taken: ☐☐/☐☐/☐☐☐☐

12. If yes to either of the above questions, please specify: _____

13. Completion Date: ☐☐/☐☐/☐☐☐☐ CSCC Staff ID: ☐☐☐

HCHS/SOL INCA MRI Pre-MRI Screening Form-Spanish
PMS ver. 5/15/2018 Spanish

ADMINISTRATIVE INFORMATION

Fecha: ☐☐/☐☐/☐☐☐☐
(mm/dd/yyy)

DOB: ☐☐/☐☐/☐☐☐☐ Staff ID: ☐☐☐
(mm/dd/yyy)

Estatura: _____ Peso: _____

Place PARTICIPANT information label here
Containing full name, HCHS ParticipantID
Site PI

***Instructions**: Participants with implants must be approved by the MRI safety officer before a MRI scan may be performed without exception.*

1. ¿Ha tenido usted, alguna vez, alguna cirugía o algún procedimiento invasivo similar, en el cual le hayan implantado algún aparato médico? No ☐ Sí ☐

   Si, sí por favor descríbalo:

   Tipo de cirugía: Fecha (mm/dd/yyyy)

   _____ ☐☐/☐☐/☐☐☐☐

   _____ ☐☐/☐☐/☐☐☐☐

2. ¿Ha tenido usted anteriormente algún estudio de imágenes de MRI? No ☐ Sí ☐

   Si sí, en que parte del cuerpo?

Parte del cuerpo	Fecha (mm/dd/yyyy)	Lugar donde Ocurrió
_____	☐☐/☐☐/☐☐☐☐	_____
_____	☐☐/☐☐/☐☐☐☐	_____
_____	☐☐/☐☐/☐☐☐☐	_____

3. ¿Ha trabajado usted, alguna vez, con metal (moliendo, fabricando, etc.) o ha recibido alguna vez alguna herida en los ojos con un objeto metálico (ej. astilla metálica, raedura, esquirla, Shrapnel, o algún cuerpo extraño)? No ☐ Sí ☐

   Si sí, por favor descríbalo: _____

Solamente para participantes de género femenino:

4. ¿Está usted embarazada o existe la posibilidad de que esté embarazada? (if unsure, please notify MRI operator or Principal Investigator) No ☐ Sí ☐
5. ¿Está usted amamantando (lactando)? No ☐ Sí ☐
6. ¿Fecha de su último ciclo menstrual?: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)
7. ¿Está usted tomando algún tipo de medicamento de fertilidad o recibiendo tratamiento para fertilidad? No ☐ Sí ☐
8. ¿Está usted tomando contraceptivos oralmente o recibiendo tratamiento hormonal? No ☐ Sí ☐

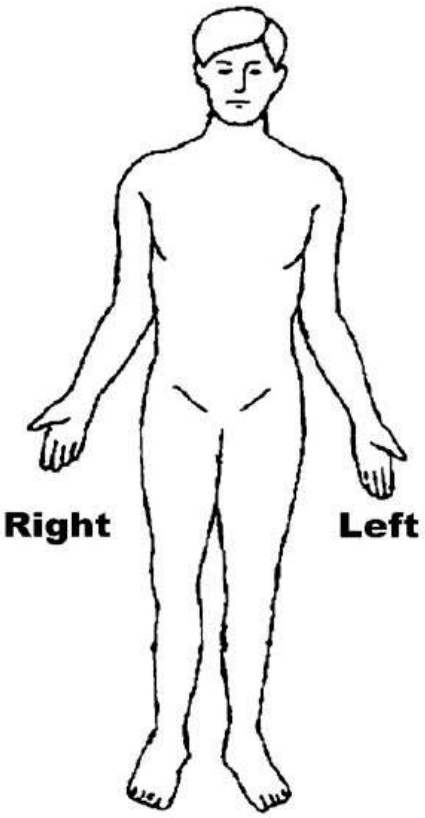
9. ¿Tiene usted historia de ataques epilépticos o epilepsia? No ☐ Sí ☐

PARTICIPANTS WITH IMPLANTS MUST BE APPROVED BY THE MRI SAFETY OFFICER BEFORE A MRI SCAN MAY BE PERFORMED WITHOUT EXCEPTION.

Algunos de los siguientes artículos pueden ser peligrosos para su seguridad y pueden interferir con el examen de MRI (Siglas en Inglés). Por favor señale la respuesta adecuada para cada una de los siguientes. Tiene usted alguno de los siguientes:

Sí	No	Ubicación del implante
☐	☐	Hardware Dental (e.g. corona de metal, brackets/braces, retenedor)
☐	☐	Marcapasos cardíaco
☐	☐	Implante cardíaco/ desfibrilador
☐	☐	Pinza(s) de aneurisma
☐	☐	Pinza vascular de la arteria carótida
☐	☐	Estimulante neural
☐	☐	Insulina o bomba de infusion
☐	☐	Implante de un aparato para la infusión de droga
☐	☐	Crecimiento óseo/ estimulante de fusión
☐	☐	Implante en la cóclea, otológica
☐	☐	Cualquier tipo de prótesis (ojo, del pene, etc.)
☐	☐	Prótesis valvular cardíaca
☐	☐	Extremidad o coyuntura (articulación) artificial
☐	☐	Electrodo (en el cuerpo, cabeza o cerebro)
☐	☐	Conducto, cánula (Stent), filtros o espirales intravasculares
☐	☐	Desviador (espinal o intraventricular)
☐	☐	Puerto de acceso vascular y/o catéter
☐	☐	Catéter Swan – Ganz
☐	☐	Algún implante sostenido en su lugar por un magneto (imán)
☐	☐	Sistema de entrega por medio de parche transdérmico (ej. Nicotina) (Quíteselo antes del MRI)
☐	☐	DIU dispositivo intrauterino o diafragma
☐	☐	Maquillaje permanente (delineador de ojos, labios, etc.)
☐	☐	Perforaciones en el cuerpo, Piercing (Quíteselos antes del MRI)
☐	☐	Algún fragmento metálico (incluyendo balas, esquirlas, sharpnel)
☐	☐	Alambres de estimulación interna
☐	☐	Clip aórtico
☐	☐	Implantes metálicos o de malla de alambre
☐	☐	Suturas metálicas o grapas quirúrgicas
☐	☐	Barras de Harrington (espinal, columna)
☐	☐	Barras de metal en los huesos
☐	☐	Reemplazo de coyunturas (articulación artificial): _____
☐	☐	Tornillos, clavos, alambres o placas en los huesos/coyunturas
☐	☐	Audífono (Quíteselo antes del MRI)
☐	☐	Dentadura postiza (Quítesela antes del MRI)
☐	☐	Desorden respiratorio
☐	☐	Desorden de movimiento
☐	☐	Claustrofobia
☐	☐	Ansiedad
☐	☐	Other: _____

Por favor señale en la figura abajo, el lugar donde tiene el implante o metal en



Antes del MRI, por favor **quítese todos los objetos metálicos** incluyendo llaves, pinzas de pelo, clip de papel, clip de billetes, monedas, bolígrafos, cinturón, botones metálicos, navajas y ropa que contiene metal en la tela.

NOTA: SE REQUIERE QUE USTED USE TAPONES DE OIDOS O AUDÍFONOS DURANTE EL EXAMEN DE MRI.

_____ Fecha: ☐☐/☐☐/☐☐☐☐

Signature/Printed name of Person Completing Form **Month Day Year**

Form completed by: ☐ Participant ☐ Relative: _____
Name & relationship to participant

☐ Physician or other: _____
Name & relationship to participant