



Attention - DO NOT enter patient data on this form if the header does not contain preprinted CRISP ID number, clinical center ID, and visit number.

Participant ID: _____ pkdid

Clinical Center: _____ pccn

visit:

MRI Status Verification

This form is to be completed for all participants at visit 8, prior to administration of the MRI.

Date of visit: *dvdate*

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1. Eligible but Modified Criteria – Part I

Review **all** possible conditions listed in section 1 with the participant. Check any that apply. If **any** of the MR contraindications in Part 1 are checked, go to section 3 and check **Eligible but Modified** for Participant Status. **Do not** complete section 2.

If none are checked, go to section 2.

- Weight > 158.6 kg (350 lbs) *weight*
- Pregnant *preg*
- Cardiac Pacemaker *cardpac*
- Implanted cardioverter defibrillator (ICD) *cardef*
- Neurostimulation system *neuron*
- Claustrophobia *claust*
- Spinal cord stimulator *spinal*

2. Eligible but Modified Criteria – Part II

Review **all** possible conditions listed in section 2 (continued on the next 2 pages) with the participant. Check any that apply. If **any** are checked, please discuss the condition(s) with the radiologist to determine if an MRI may be administered.

If none are checked, go to section 3 and check **Eligible and Enrolled**.

- Bone growth/bone fusion stimulator *bonfus*
- Cochlear, otologic, or other ear implant *earimp*
- Insulin or other infusion pump *insul*
- Implanted drug infusion device *druginf*
- Eyelid spring or wire *eyel*
- Tissue expander (e.g. breast) *tissex*



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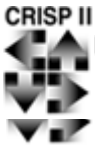
Participant ID: _____ pkdid

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<input type="checkbox"/>	Hx of working with metal <i>hxwkmet</i>
<input type="checkbox"/>	Hx of metal in eyes <i>hxmeteye</i>
<input type="checkbox"/>	Aneurysm Clip(s) <i>aneu</i>
<input type="checkbox"/>	Hearing aid <i>hearaid</i>
<input type="checkbox"/>	Embolization coils <i>emcoil</i>
<input type="checkbox"/>	Internal electrodes or wires <i>wires</i>
<input type="checkbox"/>	Any type of prosthesis (eye, penile, etc.) <i>prost</i>
<input type="checkbox"/>	Heart valve prosthesis <i>heart</i>
<input type="checkbox"/>	Metallic stent, filter, or coil <i>metst</i>
<input type="checkbox"/>	Artificial or or prosthetic limb <i>proslim</i>
<input type="checkbox"/>	Shunt (spinal or intraventricular) <i>shunt</i>
<input type="checkbox"/>	Vascular access port and/or catheter <i>vascath</i>
<input type="checkbox"/>	Radiation seeds or implants <i>radseim</i>
<input type="checkbox"/>	Swan-Ganz or thermodilution catheter <i>swan</i>
<input type="checkbox"/>	Medication patch (Nicotine, Nitroglycerine) <i>patch</i>
<input type="checkbox"/>	Any metallic fragment or foreign body <i>metfrag</i>
<input type="checkbox"/>	Wire mesh implant <i>wimeim</i>
<input type="checkbox"/>	Surgical staples, clips or metallic sutures <i>surstcl</i>
<input type="checkbox"/>	Joint replacement (hip, knee, etc.) <i>jorep</i>
<input type="checkbox"/>	Bone/joint pin, screw, nail, wire, plate, etc. <i>bojpin</i>
<input type="checkbox"/>	IUD, diaphragm or pessary <i>iud</i>
<input type="checkbox"/>	Dentures or partial plates <i>denppl</i>
<input type="checkbox"/>	Tattoo or permanent makeup <i>tattoo</i>
<input type="checkbox"/>	Body piercing jewelry <i>bopierc</i>
<input type="checkbox"/>	Other implant <i>otimp</i>
Please specify: _____ <i>impsp</i>	



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<input type="checkbox"/> Breathing problem <i>breatpr</i>
<input type="checkbox"/> Other <i>other</i>
Please specify: _____ <i>othersp</i>

3. Status: <i>finenro</i> (Check only one)
3 <input type="checkbox"/> Eligible but Modified – Continue, no MRI
4 <input type="checkbox"/> Eligible and Enrolled – Continue

CRISP Member completing this form _____

cdidnum

Date Form Completed __/__/____

cddate

Data Entry Status: Please check to indicate that the above information has been entered

Primary Entered by: _____ Date: __/__/____

deidnum

dedate

Secondary Entered by: _____ Date __/__/____