Participant Safety Screening Form

ID NUMBER: | | | | | | | |

FORM CODE: | P | S | A |

DATE: 12/11/2023
Version 4.0

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ (Month / Day / Year)

0b. Staff ID: ☐☐☐

Instructions: *This safety screening form should be administered during the appointment reminder call and again prior to the exam. Positive responses to Questions 1 – 5 should be noted on the Exam Itinerary Checklist for routing purposes during the visit.*

1. Are you on any medication for diabetes or any other medication prescribed by a physician that needs to be taken on a schedule?

   Yes ☐Y → **Report on Exam Itinerary Checklist**
   No ☐N → **Go to Item 2**

   1a. If yes, details: _____

2. Do you need any other medical support that we should be aware of?

   Yes ☐Y → **Report on Exam Itinerary Checklist**
   No ☐N → **Go to Item 3**

   2a. If yes, details: _____

3. Do you have either a heart pacemaker or defibrillator (AICD)?

   Yes ☐Y → **Report on Exam Itinerary Checklist**
   No ☐N

4. Do you have a history of skin allergic reaction to adhesive tape?

   Yes ☐Y → **Report on Exam Itinerary Checklist**
   No ☐N

5. Do you have an implanted medical device other than a pacemaker or defibrillator (AICD)?

   Yes ☐Y → **Report on Exam Itinerary Checklist**
   No ☐N

5a. If yes, please specify the type of device(s):_____