Participant Safety Screening Form

ID NUMBER: | | | | | | | |

FORM CODE: | P | S | A |

DATE: 6/6/2025
Version 5.0

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 – 4 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 an implanted medical device that is battery-operated or electrically active? [*if necessary list out examples]* Examples may include cardiac devices like a pacemaker, implantable cardioverter defibrillator (ICD), or cardiac resynchronization therapy device (CRT-P/CRT-D), neurological implants like a deep brain stimulator, vagal nerve stimulator or a spinal cord stimulator, insulin delivery devices, cochlear implants or other electronic implants like retinal implants, sacral nerve stimulator, or GI electrical stimulation device.

   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