Participant Safety Screening Form

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 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]