



STUDY PARTICIPANT INTAKE FORM

Study participant name:

Date of birth:

Study name:

Study coordinator name:

Study coordinator contact number(s):

Study backup contact number:

Where are the patients going after the imaging procedure?

If home, who is driving?

Does the patient have any cognitive impairment?

Other Important Patient Information (relevant to this visit):

Study Personnel Instructions:

Please print and bring this completed form to the research imaging check in station with the study participant.