|  |  |
| --- | --- |
| CAMRD Protocol Number: |  |
|  |
| Appointment Date and Time:  |  |
|  |
| Subject ID: |  |
|  |
| Subject Name to be entered in the “Name” field on scanner:(eg. naming convention if required by sponsor ) |  |
|  |
| Visit Time Point: (eg. Screening, V01)  |  |
|  |
| DOB or Year of Birth: (As allowed per the ICF)  |  |
|  |
| Subject Height and Weight: |  |
|  |
| Principal Investigator Name: |  |
|  |
| MRI Screening Form Complete? | ⬜ Yes ⬜ No |
|  |
| For Female Subjects: Per Duke IRB POLICY STATEMENT REGARDINGPREGNANCY TESTING, 6/5/2014; Does the Subject need a Pregnancy Test? | ⬜ No: Reason\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes: ⬜ Serum Pregnancy Test (results\_\_\_\_\_\_) Initials \_\_\_\_\_\_\_\_ ⬜ Urine Pregnancy Test (results\_\_\_\_\_\_) Initials\_\_\_\_\_\_\_\_ |
|  |
| Subject Consent Date: |  |
|  |  |
| CRC Contact Information: |  |

Printed Name of CRC Signature of CRC Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Please limit PHI to what has been outlined in the protocol and approved by the IRB.

For questions, please contact the CAMRD MRI technologist at 919-684-7400.