KU ALZHEIMER & MEMORY PROGRAM
The University of Kansas Medical Center

Potential Research Participant Information Form

Note: We are interested in volunteers with or without memory changes

All information provided will remain confidential and be kept in secured files.

Today's Date: _____

Name of Person Completing the form:_____

Relationship to Potential Research Participant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____(H)_____(W)_____(C)

Email: _____

All research on memory requires a study partner (someone who knows the research participant well) accompanying the research participant to study visits. Will you serve as a study partner or informant for studies? ___ Yes ___ No (if no, please complete the information below)

Name of Study Partner:_____

Relationship to Potential Research Participant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____(H)_____(W)_____(C)

Email: _____

How did you hear about the KU Alzheimer and Memory Program?

___ Friend
___ Family
___ TV
___ Radio
___ Newspaper ad
___ KU Alzheimer & Memory Program Website
___ Health Care Professional
___ Brochure
___ Public Presentation _____
___ Gray Hawk
___ Clinic
___ Other _____

Name of Potential Research Participant: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H)_____(W)_____(C)_____

Email: _____ Date of Birth: _____ Age: _____

Gender: ___ Male ___ Female Handedness: ___ Right ___ Left

Any memory changes? ____ Yes ____ No

If yes, when did memory changes begin? _____

Has the diagnosis of Alzheimer's disease been made? ___ Yes ___ No

Medications for Memory_____Start date_____

Some studies involve specific procedures. Does the potential research participant have a problem with any of the following procedures?

Brain MRI/CT Scans ___Yes ___No
Blood Draws ___Yes ___No
Memory Testing (paper & pencil) ___Yes ___No
Attending study visits ___Yes ___No

Medical History of Potential Research Participant	**Yes**	**No**	**If yes, when?**
Seizures			
Stroke or mini-stroke			
Diabetes			
Parkinson's Disease			
Head Injury			
Loss of consciousness?			
Hospitalization for the head injury?			
Cancer			
Pacemaker			
Heart Attack			
Heart Surgery			
Severe hearing or vision problems			
Are they corrected?			
Alcoholism			
Depression			
Claustrophobia			
Major Surgeries:			
Other severe medical problems:			

Current Medications: _____

_____

_____

Can we contact you about current or future studies on aging, dementia, and memory?
___ Yes ___ No

Thank you for taking the time to fill out this form. Please mail or fax it to the address/fax listed below. We will review your information and contact you within several weeks to discuss studies you may be eligible for. If you have any questions, comments or concerns **please feel free to contact us at (913) 588-0555 or visit our web site at http://www.KUalzheimer.org.**

Send to:
KU Alzheimer and Memory Program
Support Services
2100 W. 36th Ave., Suite 110
Kansas City, KS 66160

Or, fax to:
(913) 945-5035