UNIVERSITY OF ILLINOIS
AT URBANA-CHAMPAIGN

Department of Kinesiology & Community Health

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MEDICAL RELEASE

To the neurologist of _____D.O.B._____

Your patient has expressed interest in participating in a study investigating the effects of a training protocol for voluntary eye movements in Parkinson's Disease. We are including participants with unilateral involvement only, unilateral and axial involvement, or bilateral involvement without impairment of balance. Outcome measures include saccade latency, saccade duration, and saccade amplitude in reflexive and voluntary saccades. The protocol involves a large TV screen that will display visual targets arranged in circles of varying radii to train saccades up to 50 degrees of the participant's field of view. Participants will be asked to make approximately 120 saccades over the course of 30 min. There will be a total of eight training sessions. For participants with Parkinson's disease, pre and post assessments will be taken in an "ON" and "OFF medication state". For the "OFF-state", participants will be asked to start assessments at the time of scheduled medication intake but withhold from taking the medication for two hours. During the 2-hour testing session, in the "OFF-state", participants will perform an eye tracking assessment and the Movement Disorders Society-United Parkinson's Disease Rating Scale assessment (MDS-UPDRS). Immediately after the OFF-state eye tracking and MDS-UPDRS assessments, participants will be instructed to take their next

prescribed dose of medication and rest for 60 minutes before completing an "ON-state" eye tracking assessment. Please indicate whether in your medical judgment there are significant risks with a two-hour period delay in medication intake while performing assessments. If there is significant risk to your patient with disrupting medications they will be excluded from the study. Please complete the approval form in pages 4-7 if, in your medical judgment, this individual has no contraindications or serious health risks in participating in this study. Thank you for your time to read this summary and evaluate your patient's status for participation in this study. If you have any questions please do not hesitate to contact the principal investigator in the study, [redacted]

Thank you.

To be completed by the participant

Date_____

Name_____

Address_____

City/State/Zip_____

Phone(_____)_____E-mail_____

Date of Birth(MM/DD/YYYY)_____

Primary Diagnosis_____

Date of Diagnosis(MM/DD/YYYY)_____

Emergency Contact Name_____

Relationship_____ Phone #(_____)_____

Do you have any allergies? _____ If yes, (please specify)_____

Have you ever been diagnosed with one of the following?

Diabetes(Y/N)____(Insulin?____) Parkinson's disease____Hypertension____Pulmonary Disease____

20/20 or Corrected Vision (specify)_____Retinal Disease(specify)_____

Glaucoma_____ Ischemic Optic Neuropathy_____Pseudoexfoliation Syndrome_____ Ocular Surgery_____

Ocular Trauma_____ Cataracts_____ Orbital myositis_____ _____

Other neurological disorders/injuries apart from Parkinson's Disease?_____ If yes, what was the diagnosis?

_____

Have you undergone brain surgery (ex: for Deep Brain Stimulation)_____

_____

Are you receiving Outpatient Therapy YES_____NO_____

Please list any Surgeries including dates

_____

_____

_____

_____

Please list the medications that you are currently taking

_____

_____

_____

_____

_____

_____

Approved January 25, 2019
Expires January 24, 2020
IRB #16033

Has there been a change in use of medication in the last 6 months? YES_____NO_____

Do you have a family member or caretaker that can be present and aid in transport for the "OFF medication state" assessment days? YES_____NO_____

By signing this document, I give permission to have my neurologist mail a medical release form to Prof.

[redacted]

Signature_____Date_____

To be completed by the participant's neurologist:

Participants Name_____

Diagnosis (List All)_____

_____

Does your patient meet the UK Brain Bank Diagnostic Criteria for PD? (y/n) _____

Please check all the PD related impairments:

_____ unilateral involvement only

_____ unilateral and axial involvement

_____ bilateral involvement without impairment of balance

_____ Other/higher level of involvement

Height_____ Weight_____ Pulse_____ BP_____ Sex_____

Physical Exam	Normal	Abnormal	Explanation of Abnormalities
Head/Neck	_____	_____	_____
Eyes/Vision	_____	_____	_____
Ears/Hearing	_____	_____	_____
Heart/Lung	_____	_____	_____
G.I.	_____	_____	_____
C.N.S.	_____	_____	_____
Skin	_____	_____	_____

Dates of hospitalization over last two years with admitting diagnoses:

_____

_____

_____

_____

Significant "ABNORMAL TEST" EKG/X-RAY/LAB):_____

Medications (please list)

_____

_____

_____

_____

_____

Change in medication in the past 6 months YES_____NO_____ If yes, specify

_____

Initiation of medications that influence walking/mobility/coordination in the past 30 days?

YES_____NO_____

Do you expect any changes in medication in the next two months?

YES_____NO_____

If your patient has PD, is your patient under Deep Brain Stimulation (DBS) treatment?

YES_____NO_____

If the participant has PD, is there significant risk associated with withholding from movement related medications for two hours from the regularly scheduled intake time and resuming intake immediately after the two hour delay period?

YES_____NO_____

Do you have any modifications to the medication intake delay time and continuation of intake after the two hour delay?

YES_____NO_____

IF YES, please clarify:

_____

_____

_____

_____

_____

Is it safe for the participant to resume medications after a two hour delay period?

YES_____NO_____

IF NO, but there is s safe way to stop and resume medications, please provide Instructions on how stop and resume medication:

Approval for participation: YES_____NO_____

Comments/Restrictions: _____

Address: _____

City: _____State: _____ZIP:_____

Physician's Signature: _____

Physician's Emergency Contact Telephone Number: _____

Date: _____

Permission to release patient information to the [redacted] can be found at the bottom of page 3.

PLEASE MAIL TO:

[redacted]

THANK YOU FOR YOUR PARTICIPATION.