**Introduction:**

*Hi, my name is…from Massachusetts General Hospital, and I’m calling you back about**research studies for adults with ADHD.*

# *I first want to give you a bit of information about a specific research study. The purpose of this research study is to learn about the brain systems involved in emotional regulation and dysregulation in adults with Attention Deficit Hyperactivity. We would like to examine what areas of the brain are altered in individuals with emotional dysregulation deficits and ADHD using Magnetic Resonance Imaging (MRI). The MRI scanner uses large magnets to take pictures of your brain.*

*The purpose of today’s phone call is to see if you might be eligible for this research study.*

*If you are still interested, the next step would be to complete a 10 minute phone interview. Does this sound like a research study you would be interested in? Do you agree to continue with this phone interview? Is now a good time to complete the phone interview? If you prefer you can also come in to our office and complete this visit in person.*

**Confidentiality Statement:**

*The information you give about yourself will be kept confidential and stored securely and used only for study purposes. Your medical and mental health information will be labeled with your initials only and stored separately from any other information that could identify you, such as your name and address. You can choose not to answer any questions, and you can stop the interview at any time.*

**Preliminary Information:**

1. What are the first three letters of your full first name? (For code name).
2. What are the first three letters of your full last name? (For code name).
3. How old are you?
4. How did you hear about our office?
5. The phone number that I called you at, is that a good way to get in touch with you?
6. It is OK to identify who we are on the answering machine?

**Inclusion/Exclusion Criteria:**

* 1. **Have you ever taken any medication for attention, mood, or anxiety problems?**
     1. **If YES:** *What is the name of the medication? What did you take it for? When date/time did you start/stop the medication?*
  2. **Do you take any medication on a daily basis for any reason?**
     1. **If YES:** *What is the name of the medication? When (date/time) did you start the medication? Why do you take this medication?*
  3. **Do you take any herbal supplements, such as vitamins?**
     1. **If YES:** *What kind? How often?*
  4. **Do you have a history of severe allergies to medications or any multiple side effects?**
     1. **If YES:** *Can you tell me more about that? When was the last time you had that reaction? What happened?*
  5. **Do you have any other allergies?**
     1. **If YES:** *What are you allergic to? Do you take any medications for this?*
  6. **Have you ever had a head injury that required medical attention, like a concussion?**
     1. **If YES:** *When was this injury? What were the consequences of this injury? Did you lose consciousness? If so, for how long?*
  7. **Do you have a history of or current significant medical conditions such as heart, nervous system, liver or kidney disease?**
     1. **If YES:** *Can you tell me more about that? When was that? Any current treatment/follow-up?*
  8. **What about any chronic medical illnesses such as diabetes?**
     1. **If YES:** *Are you Type I or II Diabetic? When were you diagnosed? If Type II, are you insulin dependent?*
  9. **Any tumors or a history of cancer?**
     1. **If YES:** *What kind of cancer? When was it? Is it currently active? Malignant or benign? Are you currently in or have you had treatment for this (i.e., chemotherapy, radiation therapy, surgery, other)? Any follow-up?*
  10. **Do you have a history of high blood pressure?**
      1. **If YES:** *What is your normal blood pressure? Do you currently take medication for high blood pressure (name, dose, duration, response)? What was your blood pressure before you started the medication?*
  11. **Have you ever had a seizure before?**
      1. **If YES:** *Was it a seizure related to a fever when you were a young child? When was the last time you had a seizure? Is your condition stable?*
  12. **Do you have any sensory problems like deafness or blindness? Or any motor difficulties, like problems with walking or movement?**
      1. **If YES:** *Can you tell me more about that? When was that?*
  13. **Have you ever been hospitalized for psychiatric problems?**
      1. **If YES:** *Can you tell me more about that? Reason? Was it voluntary? How long were you there? How many times? About how long ago was that? Any follow-up?*
  14. **Have you ever been diagnosed with depression, bipolar disorder, an obsessive-compulsive disorder, psychosis or autism?**
      1. **If YES:** *Can you tell me more about that? When were you diagnosed?*

**Suicidality: If caller mentions not wanting to be alive or any thoughts of harming self, etc. –** *Do you ever have thoughts about hurting yourself? Are you currently concerned for your safety or the safety of others?*

**If YES:** GET A CLINICIAN, KEEP ON PHONE – *continue with screen by following crisis management plan – Do you have any plans to hurt yourself in the near future? When? How? Does anyone else know about this? Do you have an emergency plan?*

WHEN CLINICIAN COMES TO PHONE, say: *Usually when someone tells us they are concerned for their own safety (or the safety of others) we have a doctor come and speak with them. If that is OK with you, I am going to put the doctor on the phone now. Her/his name is…*

* 1. **Do you currently have any problems with anxiety or excessive worry?**
     1. **If YES:** *Is it currently interfering with your daily activities? How long have you felt this way? Is it a constant anxiety/worry? Or is it cued by a certain situation, thing, or place? Do you avoid certain situations because of it?*
  2. **Have you ever had a panic attack (This would be very scary feelings that come on out of the blue and your heart starts beating really fast or you feel weak and shaky)?**
     1. **If YES:** *Can you tell me more about that? Did it come out of the blue? Or was it cued by something? When was the last time you had a panic attack?*
  3. **Have you ever suffered from an eating disorder?**
     1. **If YES:** *Can you tell me more about that? Were you diagnosed? When? What are your eating habits like currently?*
  4. **Do you have trouble falling asleep?** **Or do you go to sleep late because you cannot fall asleep earlier?**
     1. **If YES:** *Can you tell me more about that (how long it takes to fall asleep or get to bed at night)? How long have you had trouble falling asleep or getting to bed like that? Do you ever take sleep aids? When was the last time you took a sleep aid?*
  5. **Have you ever been diagnosed with sleep apnea or any other sleep disorder?**
     1. **If YES:** *Can you tell me more about that? When were you diagnosed? Did you take any medication or use any treatment for this?*
  6. **Do you currently drink alcohol, even socially?**
     1. **If YES:** *How frequently do you drink? How many drinks do you have in a sitting?*
  7. **Do you use drugs currently? Have you used drugs in the past?**
     1. **If YES:** *What drug(s)? How often? How much each time? How long did you use? When was the last time you used?*
  8. **Have you ever been in trouble with the law?**
     1. **If YES:** *Can you tell me more about that? Were there any repercussions?*
  9. **Are you left-handed or right-handed?**
  10. *If female*, **Are you currently pregnant or breastfeeding?**

**MRI and PET Screening**

Now I’d like to ask you a few questions pertaining to taking an MRI.

|  |  |  |
| --- | --- | --- |
| 1. Have you ever had an MRI scan before?    1. *If yes:* of what part of the body? When? | 1 NO | 2 YES |
| 1. Have you EVER used metal grinding or welding equipment? (e.g., cutting sheet metal, jewelry)    1. (If yes: ask when, how often, can you describe?) | 1 NO | 2 YES |
| * 1. Did you ALWAYS use goggles? | 1 NO | 2 YES |
| 1. Do you have neck or back problems? (If yes, specify)    1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 1 NO | 2 YES |
| 1. Are you claustrophobic? | 1 NO | 2 YES |
| Comments: | | |

For the imaging, any metal in or on your body may distort images or might even cause harm. (Dental fillings do not distort the image or cause harm; braces or dental posts may distort the image.) Therefore it is very important for you to please let me know if you have ANY of the following (or possibility of any):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Metal Fragments in body/eyes (bullets, shrapnel) | 1 NO | | | 2 YES |
| 1. Injury to eyes involving metal (If yes, describe) | 1 NO | | | 2 YES |
| 1. Metal rods, plates, or screws in body or mouth | 1 NO | | | 2 YES |
| 1. Surgical aneurysm clips | 1 NO | | | 2 YES |
| 1. Cardiac Pacemaker | 1 NO | | | 2 YES |
| 1. Neurostimulator | 1 NO | | | 2 YES |
| 1. Implanted Pumps | 1 NO | | | 2 YES |
| 1. Prosthetic Heart Valve | 1 NO | | | 2 YES |
| 1. Ear Implants (OK, except cochlear implants) | 1 NO | | | 2 YES |
| 1. *Females only:* Are you Pregnant | 1 NO | | | 2 YES |
| 1. Are you Breast Feeding (Rule out if using Gadolinium) | 1 NO | | | 2 YES |
| 1. Do you have an IUD for birth control (if so, get brand/material) | 1 NO | | | 2 YES |
| Comments: | | | | |
| 1. *Weight/Size:* Please give me your weight\_\_\_\_\_\_\_ and height\_\_\_\_\_\_ | | | | |
| |  |  |  | | --- | --- | --- | | 1. Do you have braces? | 1 NO | 2 YES | | 1. Dentures? | 1 NO | 2 YES | | 1. Hearing Aid? | 1 NO | 2 YES | | 1. Do you wear any type of medicated patch? (If yes: “What type of patch is it?” If appropriate follow with “it will need to be removed prior to the scan for your protection”.) | 1 NO | 2 YES | | 1. Previous Surgery? (If metal left behind) | 1 NO | 2 YES | | 1. Movement Disorders? (Ticks, restless legs, etc.) | 1 NO | 2 YES | | 1. Tattoos? (Plus permanent metallic eye makeup; rule out if ink contains metallic specks. If tattoos: how many/how long ago did they get them) | 1 NO | 2 YES | | 1. Body Piercings? | 1 NO | 2 YES | | * 1. (*If yes:* “All metal jewelry/items will need to be removed prior to the scan. Is this OK?”) | 1 NO | 2 YES | | 1. Metallic clothing that cannot be removed for the scan? (Underwire bra, steel toes in shoes – must be removed at time of scan.) | 1 NO | 2 YES | | 1. Meniere’s Disease? (Hearing loss, vertigo) | 1 NO | 2 YES | | 1. Colored contact lenses? (Will need to remove for scan) | 1 NO | 2 YES | | Comments: | | |   Guidelines: Must be <350 lb; Scanner is 64” in circumference, so <60 inches around at widest point.  *If fit is questionable:*  For the MRI you will lie on a table that will slide into an opening in the scanner. To be sure you will be comfortable during the scan, we try to get an idea of your body size in relation to the scanner opening. This is why we ask your height and weight. However, HOW you carry your weight is also important, as people with larger upper bodies, meaning broad shoulders, chest, or stomach may feel more snug while in the scanner. This may sound strange, but it would be helpful for me to have your measurement around the largest part of your upper body. Then I’ll know how you will fit in the scanner opening. Do you have a measuring tape, and would it be possible for you (or a household member) to take your measurement? I can either wait or call you back.”  If subject is willing to take measurement:  “Please measure around the largest part of you upper body (typically chest or stomach), and INCLUDE your arms in the measurement. That is, be sure your arms are at rest and inside of the measuring tape. Record measurement:\_\_\_\_\_\_\_\_ | | | | |
| 1. Weight/Size: Meets criteria? | | 1 NO | 2 YES | | |

If eligible for a research study please ask the following:

**Confidential Information:**

**Name:** *Could you please spell your* ***full*** *first and last name?*

**Sex:** Fill in as applicable.

**Age:**  *Already asked.*

**Birth date:** *What is your date of birth?*

**Race:** *What do you consider your race to be?*

**Ethnicity:** *Do you consider yourself to be Hispanic or Latino?*

**Education:** *What is your highest level of education?*

**Marital Status:** *What is your current marital status?*

**Occupation:** *What is your occupation?*

**Address:** *What is your current mailing address?*

**Email:** *Do you have an email address we can contact you at?*

**Preference:** *We usually verify appointments the day before, would you rather we call or email you?*

***If sending email:*** I’m going to send you an encrypted email. This is a system we use at the hospital to protect your privacy. When the email comes, you will see “send secure” in the subject line. To open the email you’ll have to create a password and verify the password before you can log in to see the message. This will be the password you’ll use to open any messages from us. The system will guide you through the steps, but if you have any trouble opening the email, you can give us a call.