



(Affix Label Here)

Participant ID: \_\_\_\_\_

Participant Name Code: \_\_\_\_\_

Date Form Filled Out:

d d M M M y y y y  
(e.g., 10JUN2005)

Interviewer Code:

Circle Field Center Location:

BU CU DK UP

### Consent Tracking and Interview Feasibility

Please Mark the Appropriate Box Below:

- <sup>1</sup> .....This Form was Administered In-Person by Study Personnel
- <sup>2</sup> .....This Form was Administered via Telephone by Study Personnel

### Informed Consent

1. Verify that informed consent is being provided by the Participant:

- <sup>1</sup> .....Yes
- <sup>0</sup> .....No

2a. Date Participant signed LLFS Consent Form:

/    /      
d d / m m m / y y y y

2b. Version Number

**or**

Version Date

/    /      
d d / m m m / y y y y

2c. Consent form documents that participant allows blinded data/samples to be shared with other investigators:

- <sup>1</sup> .....Yes
- <sup>0</sup> .....No

2d. Consent form documents that participant allows samples to be stored for future research:

- <sup>1</sup> .....Yes
- <sup>0</sup> .....No

Participant ID: \_\_\_\_\_

Participant Name Code: \_\_\_\_\_

2e. Consent form documents participant's permission to measure cholesterol and other blood factors and release findings from tests to participant's physician.

<sup>1</sup> .....Yes  
<sup>0</sup> .....No

2f. Consent form documents participant's permission to prepare and test DNA.

<sup>1</sup> .....Yes  
<sup>0</sup> .....No

2g. Consent form documents participant's permission to create and store a cell line.

<sup>1</sup> .....Yes  
<sup>0</sup> .....No

2h. Consent form documents participant's permission to share blood samples with investigators who are not part of the study.

<sup>1</sup> .....Yes  
<sup>0</sup> .....No

3. Date Participant signed HIPAA Authorization (*not applicable to BU or UP Field Centers; see Q2a*):

//  
**d d / m m m / y y y y**

**Interview Feasibility**

| Is the Respondent able to . . . | Yes, Without <u>Any</u> Difficulty    | Yes, with <u>Little</u> Difficulty    | Yes, with <u>Great</u> Difficulty     | No                                    | N/A (Mark for Phone Visits)           |
|---------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| 4a. See?                        | <input type="checkbox"/> <sup>3</sup> | <input type="checkbox"/> <sup>2</sup> | <input type="checkbox"/> <sup>1</sup> | <input type="checkbox"/> <sup>0</sup> | <input type="checkbox"/> <sup>N</sup> |
| 4b. Hear?                       | <input type="checkbox"/> <sup>3</sup> | <input type="checkbox"/> <sup>2</sup> | <input type="checkbox"/> <sup>1</sup> | <input type="checkbox"/> <sup>0</sup> |                                       |
| 4c. Understand?                 | <input type="checkbox"/> <sup>3</sup> | <input type="checkbox"/> <sup>2</sup> | <input type="checkbox"/> <sup>1</sup> | <input type="checkbox"/> <sup>0</sup> |                                       |
| 4d. Speak?                      | <input type="checkbox"/> <sup>3</sup> | <input type="checkbox"/> <sup>2</sup> | <input type="checkbox"/> <sup>1</sup> | <input type="checkbox"/> <sup>0</sup> |                                       |

***Interviewer:*** After completing this section, please use your best judgment to determine whether any visual, auditory or cognitive impairments will make it impossible for the participant to participate in this study. If you reach this conclusion, please check the appropriate box below and write down which impairment(s) are severe enough to warrant a discontinuation of this study visit.

Participant ID: \_\_\_\_\_

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4e. Is the examination feasible?

<sup>1</sup> .....Yes

<sup>0</sup> .....No

Reason: \_\_\_\_\_

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5. Is the participant confined to *[his/her]* bed? (*Only out of bed when going to the toilet and taking a bath*)

<sup>1</sup> .....Yes

<sup>0</sup> .....No

<sup>N</sup> .....Not Applicable (Participating in Phone Visit)

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