



(Affix Label Here)

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

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

Date Form Filled Out:

Grid of 10 boxes for date entry

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:

- 1 This Form was Administered In-Person by Study Personnel
2 This Form was Administered via Telephone by Study Personnel

Informed Consent

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

- 1 Yes
0 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:

- 1 Yes
0 No

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

- 1 Yes
0 No

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

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

2e. Consent form documents participant's permission to release findings from tests and examinations to participant's physician.

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

2f. Consent form documents participant's access to Social Security Number

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

2g. Consent form documents participant's permission to prepare DNA.

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

2h. Consent form documents participant's permission to create a cell line.

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

2i. Consent form documents participant's permission to test DNA for genes relates to the main goals of study.

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

2j. Consent form documents participant's permission to test DNA for genes related to the secondary goals of the study.

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

2k. Consent form documents participant's permission to access DNA to researchers from private companies who wish to develop diagnostic lab tests or pharmaceutical therapies.

<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.

4e. Is the examination feasible?

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

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

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

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)