

**Attachment 7**

**Referral/Consent-to-Contact Form**

**<<Patient>>**

Public reporting burden of this collection of information is estimated to average 1 minute per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or an other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX)

## Referral-Consent Form

### **Provider to Complete This Section**

Thank you for your interest in the Registry of Unexplained Fatiguing Illnesses and Chronic Fatigue Syndrome (CFS) in Bibb County, Georgia. This research study is sponsored by the Centers for Disease Control and Prevention (CDC). Taking part in this study is completely voluntary. You are free to take part or not.

The information you provide below serves two purposes. First, this is your official referral; your patient cannot be part of the study without it. Second, if your patient elects not to participate, we will know the demographic information of patients who chose not to join our study. **According to the HIPAA regulations, the information requested below is insufficient to disclose the identity of your patient. Providing this information is not a violation of HIPAA.**

**Please either enter this information online at**

[www.\\$\\$.](http://www.$$.)

**OR detach and complete this portion of the form, and mail it using pre-paid postage( by Abt Associates),**

**OR telephone Abt Associates at ###-###-#### and provide the information to a registry staff person.**

Date of Referral: |\_\_|\_|\_| |\_\_|\_|\_| 20|\_\_|\_|\_|  
Mo. Day Year

Initial of Patient's First Name: \_\_

Initial of Patient's Last Name: \_\_

Patient's Year of Birth: \_\_\_\_\_

Patient's Sex (CIRCLE ONE): Male Female

Patient's Race (CIRCLE ALL THAT APPLY):

1. American Indian and Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian and Other Pacific Islander
5. White

Affix provider ID here

### **Patient to Complete This Section**

Thank you for your interest in the Registry of Unexplained Fatiguing Illnesses and Chronic Fatigue Syndrome (CFS) in Bibb County, Georgia. This is a research study sponsored by the Centers for Disease Control and Prevention (CDC).

Taking part in this study is completely voluntary. You are free to take part or not.

Please complete this portion of the form so that Abt Associates can call you about the registry, answer any questions you may have, and, with your permission, interview you.

You may enter this information online at:

[www.\\$\\$.](http://www.$$.)

Or detach and complete this portion of the form, seal it, and mail it using pre-paid postage (by Abt Associates Inc.)

Or telephone Abt Associates at ###-###-#### and provide this information to a registry staff person.

\* Name of Patient (first name/last name):

\_\_\_\_\_  
(PLEASE PRINT)

\* If patient is younger than 18 years, name of parent or guardian:

\_\_\_\_\_  
(PLEASE PRINT)

Patient's Street Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

\* Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\* Patient's Date of Birth: |\_\_|\_|\_| / |\_\_|\_|\_| / |\_\_|\_|\_|\_|\_|  
Month Day Year

Patient's Race (CIRCLE ALL THAT APPLY):

1. American Indian and Alaska Native
2. Asian
3. Black or African American
4. Native Hawaiian and Other Pacific Islander
5. White

Patient's Sex (CIRCLE ONE): Male Female

\* Fields marked with an asterisk (\*) must be answered.

Affix provider ID here

