Form Approved
OMB No.
Expiration date:

Attachment 7

Referral/Consent-to-Contact Form

<<Patient>>

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 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.$$.

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.$$

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