

## National Children's Study

### Adult Blood Data Collection Form-T1 Mom

(Only for use when CHITA is not available)

Part A: Administrative	
<p>Date:    _ _ / _ _ / _ 2_ 0_ _ _ </p> <p>Data Collector ID:  _ _ _ _ _ _ </p> <p>Visit location: Home   <input type="checkbox"/> 1   Clinic/Office   <input type="checkbox"/> 2</p> <p>Time kit opened:  _ _ : _ _  am   <input type="checkbox"/> 1                      pm   <input type="checkbox"/> 2</p> <div style="border: 1px solid black; padding: 10px; text-align: center; margin: 10px 0;"> <b>Place Adult Blood Collection -T1 Mom or Saliva BNC Collection Kit Label Here</b> </div> <p>Time collection stopped:  _ _ : _ _  am   <input type="checkbox"/> 1                      pm   <input type="checkbox"/> 2</p>	<p>Section Status (Select one) Complete   <input type="checkbox"/> 1 Partial Complete   <input type="checkbox"/> 2 Not Done   <input type="checkbox"/> 3</p> <p>Reason for Not Done/Partial (Select one)</p> <p>SP Refusal (Go to Part D)   <input type="checkbox"/> 1</p> <p>SP III/ Emergency   <input type="checkbox"/> 3</p> <p>No Time   <input type="checkbox"/> 4</p> <p>Safety Exclusions (Go to Part D)   <input type="checkbox"/> 10</p> <p>Physical Limitation (Go to Part D)   <input type="checkbox"/> 11</p> <p>Quantity Not Sufficient   <input type="checkbox"/> 14</p> <p>Defective Collection Kit   <input type="checkbox"/> 15</p> <p>Language Issue, Spanish   <input type="checkbox"/> 17</p> <p>Language Issue, Non-Spanish   <input type="checkbox"/> 18</p> <p>Cognitive Disability   <input type="checkbox"/> 20</p> <p>No Time (no appt. set for next data collection)   <input type="checkbox"/> 25</p> <p>Other, Specify _____   <input type="checkbox"/> 96</p>
Part B: Blood Pre-Screening Questions (Ask these questions at all visits when blood is drawn.)	
<p>1) Do you have hemophilia or any bleeding disorder?</p> <p style="text-align: right;">Yes (Go to Part D)   <input type="checkbox"/> 1                      No   <input type="checkbox"/> 2</p> <p style="text-align: right;">Refused   <input type="checkbox"/> 97                      Don't know   <input type="checkbox"/> 98</p>	
<p>2) Do you take any blood thinning medication, such as Coumadin or warfarin?</p> <p style="text-align: right;">Yes (Go to Part D)   <input type="checkbox"/> 1                      No   <input type="checkbox"/> 2</p> <p style="text-align: right;">Refused   <input type="checkbox"/> 97                      Don't know   <input type="checkbox"/> 98</p>	
<p>3) Have you had cancer chemotherapy within the past 4 weeks?</p> <p style="text-align: right;">Yes (Go to Part D)   <input type="checkbox"/> 1                      No   <input type="checkbox"/> 2</p> <p style="text-align: right;">Refused   <input type="checkbox"/> 97                      Don't know   <input type="checkbox"/> 98</p>	
<p>4) Have you had any problems with a blood draw in the past?</p> <p style="text-align: right;">Yes   <input type="checkbox"/> 1                      No (Go to Part C)   <input type="checkbox"/> 2</p> <p style="text-align: right;">Refused (Go to part C)   <input type="checkbox"/> 97                      Don't know (Go to Part C)   <input type="checkbox"/> 98</p>	

Public reporting burden for this collection of information is estimated to average 11 minutes 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 any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx\*). Do not return the completed form to this address.

5). What problems did you have with a blood draw in the past? (Check all that apply)		Other, Specify _____	<input type="checkbox"/> 96
Fainting	<input type="checkbox"/> 1	Refused	<input type="checkbox"/> 97
Light-headedness	<input type="checkbox"/> 2	Don't know	<input type="checkbox"/> 98
Hematoma	<input type="checkbox"/> 3		
Bruising	<input type="checkbox"/> 4		

Part C: Blood Collection Tubes			
<b>LP01</b> 3mL Lavender Prescreened	Collected <input type="checkbox"/> 1	Partial Collected <input type="checkbox"/> 2	Not Collected <input type="checkbox"/> 3
	<b>Reason for not collected or partial:</b> Equipment failure <input type="checkbox"/> 3 Fainting <input type="checkbox"/> 4 Light-headedness <input type="checkbox"/> 5 Hematoma <input type="checkbox"/> 6	Bruising <input type="checkbox"/> 7 Vein collapsed during the procedure <input type="checkbox"/> 8 Other, Specify _____ <input type="checkbox"/> 96 Refused <input type="checkbox"/> 97	
<b>RD01</b> 10 mL Red Top 01	Collected <input type="checkbox"/> 1	Partial Collected <input type="checkbox"/> 2	Not Collected <input type="checkbox"/> 3
	<b>Reason for not collected or partial:</b> Equipment failure <input type="checkbox"/> 3 Fainting <input type="checkbox"/> 4 Light-headedness <input type="checkbox"/> 5 Hematoma <input type="checkbox"/> 6	Bruising <input type="checkbox"/> 7 Vein collapsed during the procedure <input type="checkbox"/> 8 Other, Specify _____ <input type="checkbox"/> 96 Refused <input type="checkbox"/> 97	
<b>RD04</b> 10mL Red Top 04	Collected <input type="checkbox"/> 1	Partial Collected <input type="checkbox"/> 2	Not Collected <input type="checkbox"/> 3
	<b>Reason for not collected or partial:</b> Equipment failure <input type="checkbox"/> 3 Fainting <input type="checkbox"/> 4 Light-headedness <input type="checkbox"/> 5 Hematoma <input type="checkbox"/> 6	Bruising <input type="checkbox"/> 7 Vein collapsed during the procedure <input type="checkbox"/> 8 Other, Specify _____ <input type="checkbox"/> 96 Refused <input type="checkbox"/> 97	
<b>RD03</b> 10 mL Red top 03 SST	Collected <input type="checkbox"/> 1	Partial Collected <input type="checkbox"/> 2	Not Collected <input type="checkbox"/> 3
	<b>Reason for not collected or partial:</b> Equipment failure <input type="checkbox"/> 3 Fainting <input type="checkbox"/> 4 Light-headedness <input type="checkbox"/> 5 Hematoma <input type="checkbox"/> 6	Bruising <input type="checkbox"/> 7 Vein collapsed during the procedure <input type="checkbox"/> 8 Other, Specify _____ <input type="checkbox"/> 96 Refused <input type="checkbox"/> 97	

<b>LV03</b> Lavender Top 03 6 mL EDTA	Collected <input type="checkbox"/> 1      Partial Collected <input type="checkbox"/> 2      Not Collected <input type="checkbox"/> 3
	<b>Reason for not collected or partial:</b> Equipment failure <input type="checkbox"/> 3      Bruising <input type="checkbox"/> 7 Fainting <input type="checkbox"/> 4      Vein collapsed during the procedure <input type="checkbox"/> 8 Light-headedness <input type="checkbox"/> 5      Other, Specify _____ <input type="checkbox"/> 96 Hematoma <input type="checkbox"/> 6      Refused <input type="checkbox"/> 97
<b>LV02</b> Lavender Top 02 PPT	Collected <input type="checkbox"/> 1      Partial Collected <input type="checkbox"/> 2      Not Collected <input type="checkbox"/> 3
	<b>Reason for not collected or partial:</b> Equipment failure <input type="checkbox"/> 3      Bruising <input type="checkbox"/> 7 Fainting <input type="checkbox"/> 4      Vein collapsed during the procedure <input type="checkbox"/> 8 Light-headedness <input type="checkbox"/> 5      Other, Specify _____ <input type="checkbox"/> 96 Hematoma <input type="checkbox"/> 6      Refused <input type="checkbox"/> 97
<b>LV04</b> Lavender Top 04 P100	Collected <input type="checkbox"/> 1      Partial Collected <input type="checkbox"/> 2      Not Collected <input type="checkbox"/> 3
	<b>Reason for not collected or partial:</b> Equipment failure <input type="checkbox"/> 3      Bruising <input type="checkbox"/> 7 Fainting <input type="checkbox"/> 4      Vein collapsed during the procedure <input type="checkbox"/> 8 Light-headedness <input type="checkbox"/> 5      Other, Specify _____ <input type="checkbox"/> 96 Hematoma <input type="checkbox"/> 6      Refused <input type="checkbox"/> 97
<b>Blood Collection Comment:</b> _____ _____ _____	
<b>Part D Saliva BNC Collection (Only use if blood collection is refused or not possible)</b>	
Because you have hemophilia, are taking blood thinning medication, have had chemotherapy recently, or refused the blood draw, we will not be able to draw your blood at this time. Several measures that are performed in blood can be measured in saliva. Are you able to provide a saliva sample?      Yes <input type="checkbox"/> 1      No <input type="checkbox"/> 2 <b>BE SURE TO REVIEW SALIVA SAMPLE COLLECTION INSTRUCTIONS WITH THE PARTICIPANT</b>	
Collected <input type="checkbox"/> 1      Partial Collected <input type="checkbox"/> 2      Not Collected <input type="checkbox"/> 3	

<b>Reason not done or partial:</b> No time <input type="checkbox"/> 1 SP III/Emergency <input type="checkbox"/> 2 Equipment failure <input type="checkbox"/> 3	Other, Specify _____ <input type="checkbox"/> 96 Refuse <input type="checkbox"/> 97 Could not obtain <input type="checkbox"/> 99
<b>Saliva Comments:</b> <hr/> <hr/> <hr/>	
<b>Part E: Transport Temperatures</b>	
Time placed in cold compartment for transport to SPSC:       _ _ : _ _  am <input type="checkbox"/> 1    pm <input type="checkbox"/> 2 Cold Compartment temperature:       _ _ .  _  °C Cold Compartment Upper (15 °C) Temperature Threshold Monitor has been activated    Yes <input type="checkbox"/> 1    No <input type="checkbox"/> 2 Cold Compartment Lower (0 °C) Temperature Threshold Monitor has been activated    Yes <input type="checkbox"/> 1    No <input type="checkbox"/> 2 Ambient Compartment Temperature Threshold Monitor has been activated                Yes <input type="checkbox"/> 1    No <input type="checkbox"/> 2 (The ambient compartment is only used for P100 tubes that have not been centrifuged)	