HFHS Letterhead

Date

Patient name
Address 1
City State Zip

Dear [Patient's name]:

As a Henry Ford patient and a member of Health Alliance Plan, you are being asked to fill out a survey about colon cancer screening and your experiences talking with your primary care doctor about it. We are very interested in your opinions, even if you have never been screened for colon cancer and even if you filled out a similar survey in the past. This survey will take about 20 minutes to complete. We have enclosed $10 in appreciation for your time and effort.

Henry Ford Hospital and Medical Centers work to give patients the best health care possible and you taking part in this study will help us do this. The Centers for Disease Control and Prevention, Battelle Centers for Public Health Research, and Henry Ford are working together on this study. To participate, all you need to do is complete the enclosed survey. Your responses will be private and will be combined with answers from other people. Please do not put your name on the survey. We will not identify any person who was in the study in any papers or reports. None of your responses will be shown to your doctor.

Your participation in this research study is voluntary. Your returning this survey lets us know that your have agreed to participate. You are free to choose to complete this survey or not. You may receive a reminder to fill it out if you do not return the survey or letter telling us you want to opt out. If you are uncomfortable with any questions, you do not have to answer them. If you do not want to complete the survey, it will not change the care you get at Henry Ford or your coverage through HAP, and you may keep the $10. Taking part in this survey does not mean that you have to take part in future surveys.

Please send your survey in the envelope provided. If you have any questions about this research study, please call (HFHS Coordinator) at (xxx) xxx-xxxx. If you have questions about your rights as a research subject, you may contact Henry Ford Health System IRB Coordinator at (xxx) xxx-xxxx. The IRB is a group of people who review the research to protect your rights. If you do not want to be contacted again about this survey, please sign your name below and return this page to us within two weeks.

Sincerely,

Jennifer Elston Lafata, PhD
Research Scientist
Center for Health Services Research

_____does not want to take part in this survey.
Signature

ABQ HP Letterhead

Date

Patient name
Address 1
City State Zip

Dear [Patient's name]:

As an ABQ Health Partners patient and a member of Lovelace Health Plan, you are being asked to fill out a survey about colon cancer screening and your experiences talking with your primary care provider about it. We are very interested in your opinions, even if you have never been screened for colon cancer and even if you filled out a similar survey in the past. This survey will take about 20 minutes to complete. We have enclosed $10 in appreciation for your time and effort.

ABQ Health Partners and Lovelace Health Plan work to give patients the best health care possible and you taking part in this study will help us do this. The Centers for Disease Control and Prevention, Battelle Center for Public Health Research, and Lovelace Clinic Foundation, a local research organization, are working together on this study. Please do not put your name on this survey. Your responses will be private and will be combined with answers from other people. We will not identify any person who was in the study in any papers or reports. None of your responses will be shown to your doctor.

Your participation in this research study is voluntary. You are free to choose to complete this survey or not. You may receive a reminder to fill it out if you do not return the survey or letter telling us you want to opt out. If you are uncomfortable with any questions, you do not have to answer them. If you do not want to complete the survey, it will not change the care you get at ABQ Health Partners or your coverage through Lovelace Health Plan, and you may keep the $10. Taking part in this survey does not mean that you have to take part in future surveys

Please return your survey and signed HIPAA form in the envelope provided. The HIPAA form lets us know that you have agreed to participate, and must be returned for us to include your survey answers. If you do not want to be in this study, you may check the box and sign your name at the end of this letter and return it to us with or without your survey in the enclosed envelope.

For questions about your rights as a research participant, you may call Independent Review Consulting, the Lovelace Clinic Foundation's Institutional Review Board (IRB), at (800-472-3241) during weekday hours Pacific Standard Daylight Time. The IRB is a group of people who review research. They help make certain that the rights and welfare of the study participants are protected. They also make certain that the study is carried out

in an ethical manner. If you have any questions about this research study, please call (ABQ Study Coordinator) at (xxx) xxx-xxxx.

Sincerely,

April L. Salisbury
Study Coordinator
Lovelace Clinic Foundation

❑ I do not want to participate in this study.

_____ _____
Name Date