

National Children's Study

Father Blood Draw Data Collection Form

Part A: Administrative	
Date: _ _ / _ _ / _ 2_ 0_ _ _	Section Status (Select one) Complete <input type="checkbox"/> 1 Partial Complete <input type="checkbox"/> 2 Not Done <input type="checkbox"/> 3
Assignment ID: _ _ _ _ _ _ _ _ _	Reason for Not Done/Partial (Select one) Safety Exclusion <input type="checkbox"/> 1 Physical Limitations <input type="checkbox"/> 2 Participant Ill/Emergency <input type="checkbox"/> 3 Equipment Failure <input type="checkbox"/> 4 Communication Problem <input type="checkbox"/> 5 No Time <input type="checkbox"/> 6 Other Specify _____ <input type="checkbox"/> 96 Refused <input type="checkbox"/> 97 Don't know <input type="checkbox"/> 98
Participant ID: _ _ _ _ _ _ _ _ _	
Data Collector ID: _ _ _ _ _ _ _ _ _	
Site ID: _ _ _ _ _ _ _ _ _	
Participant's age _ _ years	
Part B: Blood Collection Questions (Ask these questions at all visits when blood is drawn.)	
1) Do you have hemophilia or any bleeding disorder? <input type="checkbox"/> 1 Yes (Go to Part C) <input type="checkbox"/> 2 No <input type="checkbox"/> 97 Refuse <input type="checkbox"/> 98 Don't Know	
2) Do you take any blood-thinning medication, such as Coumadin or Warfarin? <input type="checkbox"/> 1 Yes (Go to Part C) <input type="checkbox"/> 2 No <input type="checkbox"/> 97 Refuse <input type="checkbox"/> 98 Don't Know	
3) Have you had cancer chemotherapy within the past 4 weeks? <input type="checkbox"/> 1 Yes (Go to Part C) <input type="checkbox"/> 2 No <input type="checkbox"/> 97 Refuse <input type="checkbox"/> 98 Don't Know	
4) Have you had any problems with a blood draw in the past? <input type="checkbox"/> 1 Yes <input type="checkbox"/> 2 No (Go to Q 6) <input type="checkbox"/> 97 Refuse (Go to Q 6) <input type="checkbox"/> 98 Don't Know (Go to Q 6)	

5) What problems did you have with a blood draw in the past? (Check all that apply)

- Fainting 1
- Light-Headedness 2
- Hematoma 3
- Bruising 4
- Other Specify _____ 96
- Refused 97
- Don't Know 97

6) When was the last time you had anything to eat or drink?

____:____ 1 am 2 pm

7) Is this a fasting blood sample? (If the answer to Question 6 is less than 8 hours ago the answer is No.)

1 Yes 2 No

Part C Saliva Collection (Only use if blood collection is refused or not possible)

8) Because you {have hemophilia; are taking blood thinning medication; have had chemotherapy recently} 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? 1 Yes 2 No

BE SURE TO REVIEW SALIVA SAMPLE COLLECTION INSTRUCTIONS WITH THE PARTICIPANT

Kit ID: _____

9) Saliva collection status 1 Collected 2 Not Collected

Reason for not collecting

- No Time 1
- Participant Ill/Emergency 2
- Equipment Failure 3
- Other Specify _____ 96
- Refused 97
- Don't Know 98
- Could Not Obtain 99

Saliva Comments:

Part D Tubes to be Drawn		
Kit ID: <input type="text"/>		
Red top (10ml)	<input type="checkbox"/> 1 Collected <input type="checkbox"/> 2 Not Collected	Hematoma <input type="checkbox"/> 6
	Reason for not collecting:	Bruising <input type="checkbox"/> 7
	No time <input type="checkbox"/> 1	Vein Collapsed During the Procedure <input type="checkbox"/> 8
	Participant III/Emergency <input type="checkbox"/> 2	No Suitable Vein <input type="checkbox"/> 9
	Equipment Failure <input type="checkbox"/> 3	Other, Specify _____ <input type="checkbox"/> 96
	Fainting <input type="checkbox"/> 4	Refuse <input type="checkbox"/> 97
	Light-Headedness <input type="checkbox"/> 5	Don't Know <input type="checkbox"/> 98
Tube barcode	<input type="text"/>	
Lavender top (10ml)	<input type="checkbox"/> 1 Collected <input type="checkbox"/> 2 Not Collected	Hematoma <input type="checkbox"/> 6
	Reason for not collecting:	Bruising <input type="checkbox"/> 7
	No Time <input type="checkbox"/> 1	Vein Collapsed During the Procedure <input type="checkbox"/> 8
	Participant III/Emergency <input type="checkbox"/> 2	No Suitable Vein <input type="checkbox"/> 9
	Equipment Failure <input type="checkbox"/> 3	Other, Specify _____ <input type="checkbox"/> 96
	Fainting <input type="checkbox"/> 4	Refuse <input type="checkbox"/> 97
	Light-Headedness <input type="checkbox"/> 5	Don't Know <input type="checkbox"/> 98
Tube barcode	<input type="text"/>	
Pre-screened lavender top (10ml)	<input type="checkbox"/> 1 Collected <input type="checkbox"/> 2 Not Collected	Hematoma <input type="checkbox"/> 6
	Reason for not collecting:	Bruising <input type="checkbox"/> 7
	No Time <input type="checkbox"/> 1	Vein Collapsed During the Procedure <input type="checkbox"/> 8
	Participant III/Emergency <input type="checkbox"/> 2	No Suitable Vein <input type="checkbox"/> 9
	Equipment Failure <input type="checkbox"/> 3	Other, Specify _____ <input type="checkbox"/> 96
	Fainting <input type="checkbox"/> 4	Refuse <input type="checkbox"/> 97
	Light-Headedness <input type="checkbox"/> 5	Don't Know <input type="checkbox"/> 98
Tube barcode	<input type="text"/>	
ACD/PBMC tube	<input type="checkbox"/> 1 Collected <input type="checkbox"/> 2 Not Collected	Hematoma <input type="checkbox"/> 6
	Reason for not collecting:	Bruising <input type="checkbox"/> 7
	No Time <input type="checkbox"/> 1	Vein Collapsed During the Procedure <input type="checkbox"/> 8
	Participant III/Emergency <input type="checkbox"/> 2	No Suitable Vein <input type="checkbox"/> 9
	Equipment Failure <input type="checkbox"/> 3	Other, Specify _____ <input type="checkbox"/> 96
	Fainting <input type="checkbox"/> 4	Refuse <input type="checkbox"/> 97
	Light-Headedness <input type="checkbox"/> 5	Don't Know <input type="checkbox"/> 98
Tube barcode	<input type="text"/>	

Blood Collection Comment: _____ _____ _____ _____
