Multi-Ethnic Study of Atherosclerosis



Physician Questionnaire: Cardiac/PVD

Participant ID: 8000028 02

Sequence Num:

1 1	NESA Field
Cente	r use only)

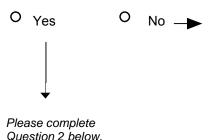
Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency 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 0925-0493. Do not return the completed form to this address.

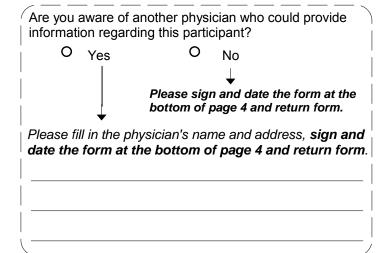
Participant Name: _	Date-of-Birth:/	
---------------------	-----------------	--

Please complete <u>only this page</u> if participant has not had any condition listed in Question 2 below, OR if you are not familiar with participant's medical history.

Please fill in the appropriate bubbles and write responses in the blanks provided.

1. Are you familiar with the participant's medical history?





2. In your opinion, has the participant had any of the conditions below? (Please check any that apply.)

O MI Please complete section A on page 2.
 O Angina Please complete section B on page 2.
 O CHF Please complete section C on page 2.
 O PAD/AA* Please complete section D on page 2.

If participant has had any of the conditions listed, we would appreciate copies of pertinent office notes, including physical exams, reports of stress tests, caths and EKGs.

O None Please sign and date at the bottom of page 4 and return form.

^{*} Peripheral Arterial Disease/Aortic Aneurysm.

8000028 02

A. Myocardial Infarction Has the participant ever been diagnosed with a myocardial infarction? O Yes O No Unknown If "Yes," when was the most recent event of this type? Dav Year Was the participant hospitalized? O Unknown O Yes O No If "Yes," where was the participant hospitalized? Name of Hospital: ___ City, State: _____ The certainty of the diagnosis is: O Definite O Probable Go to next relevant section or, if none, skip to Question 3. B. Angina Has the participant ever been diagnosed with angina pectoris or coronary insufficiency? O Yes O No O Unknown If "Yes," did s/he have chest pain or equivalent, or was the diagnosis only the result of diagnostic tests? O Pain or pain equivalent O No pain; diagnostic testing only If pain (or pain equivalent), when was the most recent episode of this type? Was the participant hospitalized for angina/coronary insufficiency? O Yes O No O Unknown If "Yes," where was the participant hospitalized? Name of Hospital:

C. CHF Has the participant ever been diagnosed with congestive heart failure or congestive cardiomyopathy? O Yes O No O Unknown If "Yes," when was the most recent episode of this type? Month Day Was the participant hospitalized? O Yes O No O Unknown If "Yes," where was the participant hospitalized? Name of Hospital: City, State: The certainty of the diagnosis is: O Definite Probable Go to next relevant section or, if none, skip to Question 3. D. PAD Has the participant ever been diagnosed with claudication, peripheral artery disease, or abdominal aortic aneurysm? O Yes O No O Unknown If "Yes," when was the most recent episode of this type? Was the participant hospitalized? O Yes O No O Unknown

Go to next relevant section or, if none, skip to Question 3.

Probable

If "Yes," where was the participant hospitalized?

City. State:

The certainty of the diagnosis is:

O Definite

Name of Hospital:

City, State:

O Definite

The certainty of the diagnosis is:

Probable

Go to next relevant section or, if none, skip to Question 3.

Physician Questionnaire: Cardiac/PVD (Page 3)

8000028 02

3. Please complete the following sections for the most recent event.

If participant has been diagnosed with MI, Angina or CHF, please complete all sections on pages 3 and 4.

If participant has been diagnosed with PAD only, complete only relevant items in sections a and b.

Section a.				
Which (if any) of the following diagnostic tests did the participant have? (Please attach copy of report.)				
		Yes	No	Unknown
Electroca	rdiogram	0	0	0
Trial of Nitr	oglycerin	0	0	0
Excercise Tolera	nce Test	0	0	0
With Tha	llium?	0	0	0
Cardiac E	Enzymes	0	0	0
Echocardiogram		0	0	0
Angiography		0	0	0
Chest X-Ray		0	0	0
	Other	0	0	0
If Other, please specify:				
Pertinent Results	b:			

Section b.			
Which (if any) of the following When were they perfo	-	ıres wer	re done?
Cardiac Catheterization Date: Month / Day	Yes O /	No O Year	Unknown O
Angioplasty or Stent Placement Date: /	Yes O	No O Year	Unknown O
CABG (Coronary Artery Bypass Graft) Date: /	Yes O /	No O Year	Unknown O
Intravenous or Intracoronary Thrombolytic Therapy (TPA, Streptokinase) Date:	Yes O /	No O Year	Unknown O
Leg angioplasty or other leg revascularization Date: /	Yes O /	No O Year	Unknown O

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Section c.			
Which (if any) of the following medications were prescribed as a therapy?			
	Yes	No	Unknown
Nitroglycerin	0	0	0
Beta-Blockers	0	0	0
Calcium Channel Blockers	0	0	0
Aspirin	0	0	0
Diuretics	0	0	0
Ace Inhibitors	0	0	0
Digitalis	0	0	0
Oxygen	0	0	0
Other Vasodilators	0	0	0
Other	0	0	0
If other, please specify:			

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Section d.			
Were any of the following present	t?		
	Yes	No	Unknown
Chest pain	0	0	0
Jugular Venous Distention	0	0	0
Cartoid Bruit	0	0	0
Basilar Rales or Crackles Only	0	0	0
Rales or Crackles Above Bases	0	0	0
Wheezing	0	0	0
S-3 Gallop	0	0	0
Cardiac Murmur	0	0	0
Hepatojugular Reflex	0	0	0
Hepatomegaly	0	0	0
Peripheral/Ankle Edema	0	0	0

Thank you very much for your contribution to MESA. Please sign and date this questionnaire and return it to us in the self-addressed, stamped envelope with copies of pertinent office notes or tests. If you do not have the envelope, the address is:

otes:	
Form completed by:	Date:
For MESA Field Center Use Only: Reviewer ID: Data Entry ID:	

OMB #0925-0493	Fyn: XX/XXXX
CIVID TUBLUTUBU	$\square \land \square \land$

Multi-Ethnic Study of Atherosclerosis



Physician Questionnaire: Cardiovascular Death

Participant ID: 8000028 02

Hospital Code:

Sequence Num:



Public reporting burden for this collection of information is estimated to average 10 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- . Do not return the completed form to this address.

Please complete the following questions to the best of your ability by filling in the appropriate bubbles or writing the answer in the blank provided. Please return completed forms in the self addressed stamped envelope provided. Thank you for your contribution to MESA.

Details of Death
Are you familiar with the events surrounding the decendent's death?
O Yes O No
2. Did you witness the death?
O Yes O No
If you answered "Yes" to both or either of Questions 1 and 2, please skip to Question 4.
3. If you answered "No" to both Questions, are you aware of another physician who could provide information regarding the death?
O Yes O No
If "No," please sign and date the form at the bottom of page 2.
If "Yes," please provide the physician's name and address, then sign and date the form at the bottom of page 2.
Name of physician:
Address:

<u>Circumstances Surrounding Death</u>

- **4.** What do you believe to be the underlying cause of death?
 - Acute Myocardial Infarction
 - O Other Ischemic Heart Disease
 - Cerebrovascular Disease
 - Other Cardiovascular Disease
 - Non-Cardio/Cerebrovascular (Please specify)

5. Please specify the time between the onset of the acute episode of symptoms and death. (We are defining death as the point where spontaneous breathing ceased and the patient never recovered.) Please check the

O Less than 5 minutes

appropriate time period.

O 5 minutes to 1 hour

O 1 hour to 24 hours

More than 24 hours

O Unknown

6. Was there an acute episode of pain in the chest, left arm or jaw during the last 72 hours prior to death?

O Yes

O No

O Unknown

7. Was there an acute episode of shortness of breath during the 72 hours prior to death?

O Yes

O No

O Unknown

8. Did the decendent take or was s/he given nitrates or nitroglycerin at the time of the acute episode?

O Yes

O No

O Unknown

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8000028 02

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\	
Medical History	Transient Ischemic Attack (TIA)
9. Are you familiar with the decendent's medical history?	O Yes O No O Unknown
O Yes O No	If "Yes," date of first diagnosis:
If you answered "No," please skip to the bottom of the page	
10. Did the decendent have a medical history of any of the following conditions or medications prior to the acute event which led to death?	Month Day Year Intermittent Claudication or Other Peripheral
Myocardial Infarction (MI)	Vascular Disease (PVD)
O Yes O No O Unknown	O Yes O No O Unknown
If "Yes," date of most recent MI:	Lower Extremity Bypass, Angioplasty or Amputation Secondary to PVD
	O Yes O No O Unknown
Month Day Year	Coronary Bypass Surgery
Angina Pectoris, Coronary Insufficiency or Other Chronic Ischemic Heart Disease	O Yes O No O Unknown
O Yes O No O Unknown	Coronary Angioplasty
If "Yes," date of first diagnosis:	O Yes O No O Unknown
	11. If you saw the participant within one month of death, please fill out the following for the most recent visit:
Month Day Year	Date of Visit:
Congestive Heart Failure (CHF) or Congestive Cardiomyopathy	
O Yes O No O Unknown	Month Day Year
Stroke (CVA)	Chief Complaint:
O Yes O No O Unknown	
If "Yes," date of most recent CVA:	Primary Diagnosis:
Month Day Year	Changes in Medical Management:
Continued next column	
Form completed by:	Date:
For MESA Field Center Use Only:	Reviewer ID: Data Entry ID:

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Multi-Ethnic Study of Atherosclerosis

Participant ID: 8000028 12

Sequence Num: (For MESA Field Center use only)

Physician Questionnaire:
Stroke/TIA

OMB #0925-0493 Exp: XX/XXXXX

Participant ID: 8000028 12

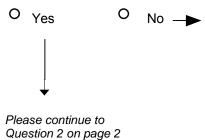
Sequence Num: (For MESA Field Center use only)

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Please complete only this page if you are not familiar with this participant's medical history.

Please fill in the appropriate bubbles and write responses in the blanks provided.

 Are you familiar with the participant's medical history?



	f another physician who could provide rding this participant?
O Yes	O _{No}
	Please sign and date the form at the bottom of page 3 and return form.
	ohysician's name and address, sign and the bottom of page 3 and return form.

2. When did you last see the patient?
Month Day Year
World Bay real
3. In your opinion, has the patient ever had a cerebrovascular event such as a stroke, TIA or amaurosis fugax?
O Yes O No O Unsure
If "No," skip to the end of the form,
sign and date at the bottom of page 3 and return form
4. When was the most recent event of this type?
Month Day Year
4a. This most recent event was a(n):
O Subarachnoid hemorrhage
O Intraparenchymal hemorrhage
O Brain infarction
O TIA
O Stroke, uncertain type
O Not a stroke or TIA
If not a stroke or TIA, what was the diagnosis?
All The explaints of the discouncils in
4b. The certainty of the diagnosis is: O Definite
O Definite O Probable
O Possible
- i dddidio
4c. Was the patient hospitalized?
O Yes O No — If "No," skip to Question 5.
Name of Hospital:
City/State:

The symptoms were in the distribution of which vest O Right carotid O Left carotid O Vertebral/Basilar O Unknown Mich (if any) of the following diagnostic tests did the patient have? Yes No Unknown To fithe head O O O O MRI of the brain O O O Carotid ultrasound O O O Electrocardiogram O O O O O O O O O O O O O O O O O O O	O Right carotid	distrib	ution of	المحمد والماسا
O Left carotid O Vertebral/Basilar O Unknown 6. Which (if any) of the following diagnostic tests did the patient have? Yes No Unknown CT of the head O O O O MRI of the brain O O O Carotid ultrasound O O O DElectrocardiogram O O O DEchocardiogram O O O O O O O O O O O O O O O O O O O	2		ulion oi	wnich vessei
O Vertebral/Basilar O Unknown 6. Which (if any) of the following diagnostic tests did the patient have? Yes No Unknown CT of the head O O O MRI of the brain O O O O O O O O O O O O O O O O O O O	O Left carotid			
O Unknown 6. Which (if any) of the following diagnostic tests did the patient have? Yes No Unknown CT of the head O O O MRI of the brain O O O Carotid ultrasound O O O Electrocardiogram O O O Hypercoagulation work-up O O O Other O O O If other, Please specify: 7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknown Severe headache O O O Diminished level of conciousness O O O Language deficit/aphasia O O O Language deficit/aphasia O O O Hemineglect O O O Dysarthria O O O Weakness or drift O O O Hemiplegia O O O Ataxia	Cert Carollu			
6. Which (if any) of the following diagnostic tests did the patient have? Yes No Unknown CT of the head O O O MRI of the brain O O O Carotid ultrasound O O O Electrocardiogram O O O Electrocardiogram O O O Hypercoagulation work-up O O O Other O O O If other. Please specify: 7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknow Severe headache O O O Diminished level of conciousness O O O Language deficit/aphasia O O O Language deficit/aphasia O O O Hemineglect O O O Sysarthria O O O Weakness or drift O O O Hemiplegia O O O Ataxia	O Vertebral/Basilar			
Patient have? Yes No Unknown CT of the head O O O MRI of the brain O O O Carotid ultrasound O O O Electrocardiogram O O O Hypercoagulation work-up O O O Other O O O Other O O O Other If other, Please specify: 7. Which (if any) of the following symptoms or physica findings were present in the most recent event? Yes No Unknow Severe headache O O O Diminished level of conciousness O O O Language deficit/aphasia O O O Language deficit/aphasia O O O Hemineglect O O O Dysarthria O O O Weakness or drift O O O Hemiplegia O O O A Ataxia	O Unknown			
CT of the head MRI of the brain Carotid ultrasound Electrocardiogram Echocardiogram O O Hypercoagulation work-up Other If other, Please specify: 7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknow Severe headache Diminished level of conciousness Loss of conciousness O Language deficit/aphasia Hemineglect Dysarthria Visual field deficit Weakness or drift Hemiplegia Ataxia		ng dia	gnostic	tests did the
MRI of the brain OOOOO Carotid ultrasound OOOO Electrocardiogram OOOOO Hypercoagulation work-up OOOO Other OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO				_
Carotid ultrasound O O O Electrocardiogram O O O O O O O O O O O O O O O O O O O		•	0	•
Electrocardiogram		0	0	0
Echocardiogram O O O O Hypercoagulation work-up O O O O O O O O O O O O O O O O O O O	Carotid ultrasound	0	0	0
Hypercoagulation work-up O O O Other O O O O If other, Please specify: 7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknow Severe headache O O O Diminished level of conciousness O O O Language deficit/aphasia O O O Language deficit/aphasia O O O Unknow O O O Language deficit/aphasia O O O O Weakness or drift O O O O Weakness or drift O O O O Hemiplegia O O O O	Electrocardiogram	0	0	0
Other OOOO If other, Please specify: 7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknow Severe headache OOOO Diminished level of conciousness OOOO Loss of conciousness OOOO Language deficit/aphasia OOOO Hemineglect OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	Echocardiogram	0	0	0
If other, Please specify: 7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknow Severe headache O O O O Diminished level of conciousness O O O C Language deficit/aphasia O O O C Language deficit/aphasia O O O C Language deficit/aphasia O O O C C Dysarthria O O O O C C C C C C C C C C C C C C C	Hypercoagulation work-up	0	0	0
Please specify: 7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknow Severe headache O O O O Diminished level of conciousness O O O O Loss of conciousness O O O O Language deficit/aphasia O O O O Hemineglect O O O O O Visual field deficit O O O O O Weakness or drift O O O O O Hemiplegia O O O O O O O O O O O O O O O O O O O	Other	0	0	0
7. Which (if any) of the following symptoms or physical findings were present in the most recent event? Yes No Unknow Severe headache O O O O O O O O O O O O O O O O O O O	Please			
Diminished level of conciousness OOOO Loss of conciousness OOOO Language deficit/aphasia OOOO Hemineglect OOOO Dysarthria OOOO Visual field deficit OOOO Weakness or drift OOOOO Hemiplegia OOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	findings were present in th	e mos 'es	t recent No	event? Unknown
conciousness Loss of conciousness O C Language deficit/aphasia Hemineglect Dysarthria Visual field deficit Weakness or drift Hemiplegia Ataxia O O O O O O O O O O O O O		O	O	O
Language deficit/aphasia O O O O Hemineglect O O O O O O O O O O O O O O O O O O O	conciousness	0	0	0
Hemineglect O O O Dysarthria O O O Visual field deficit O O O Weakness or drift O O O Hemiplegia O O O Ataxia O O	Loss of conciousness	0	0	0
Dysarthria O O O Visual field deficit O O Weakness or drift O O Hemiplegia O O O Ataxia O O		•	•	•
Visual field deficit O O O Weakness or drift O O O Hemiplegia O O O Ataxia O O O	_			
Hemiplegia O O O Ataxia O O O				
Ataxia O O O		0	0	
Sensory deficit O O O		\sim	\sim	_
	Hemiplegia			
Asymmetry of reflexes O O O	Hemiplegia Ataxia	0	0	0
Abnormal gait O O O	Hemiplegia Ataxia Sensory deficit Asymmetry of reflexes	0 0	0 0	0 0
Other O O O	Hemiplegia Ataxia Sensory deficit Asymmetry of reflexes Babinski	0 0 0	0 0 0	0 0
If other, please	Hemiplegia Ataxia Sensory deficit Asymmetry of reflexes Babinski Abnormal gait	0 0 0 0	0 0 0 0	0 0 0 0

8.	Did any neurological findir	nas persi	st longei	r than	10.	When was the first event of this type?
	24 hours from onset?	0 1	J			
	O Yes O	No				
	\				Mo	onth Day Year
	Please specify:					
					10a.	This first event was a(n):
						Subarachnoid hemorrhage
					0	Intraparenchymal hemorrhage
9.	Which (if any) of the follow	wing med	dications	were		Brain infarction
	prescribed as therapy?	V				TIA
	Aspirin	Yes O	No	Unknown O		Stroke, uncertain type
	Дэриш	O	0	O		Not a stroke or TIA
	Dipyridamole	0	0	0		If not a stroke or TIA, what was the diagnosis?
	Anti-coagulants	0	0	0		
	Ticlopidine or Clopidogrel	0	0	0	10b.	The certainty of the diagnosis
	Extended Release	0	0	0		Definite
	Dipyridamole					Probable
	Other	0	0	0		Possible
	If other, please				10c.	Was the patient hospitalized?
	specify: L				100.	
						O _{Yes} O _{No}
	If there has been more			of this type,		If "No," skip to Question 5.
	please continue to Que	stion 10.	•		Name	e of hospital:
	If not, please skip to the				C:4/	Diata.
	date, and return the for	m to tne	MESA	ciinic.	City/	State:
	•		•			MESA. Please sign and date this
	questionnaire and	d retur	n it to	us in the s	elf-ado	Iressed, stamped envelope. If you

do not have the envelope, the address is:

Form completed by:														Da	Date:								
									•		-												
Γ	For MI	ESA I	Field (Cente	r Use	Only								_		. – .							
For MESA Field Center Use Only:								Rev	ewer I	D:	<u>_ Da</u>	<u>ta Ent</u>	ry ID:										
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11/09/2004

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E.2.2 HOSPCOV (Cover letter to hospital to obtain medical records)

[date]

[hospital name]

[hospital street address]

[hospital city, state zip]

Dear Correspondence Clerk:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution]**, along with five other centers in the United States.

[participant] (date of birth [date of birth]), a participant in our study, was a patient at [hospital name] during [year]. Enclosed you will find a release of medical information signed by [next of kin name]. We are needing medical records involving that hospitalization including ER report, History and Physical, Discharge ICD-9 codes, Discharge Summary, Progress Notes, ECGs and Enzyme reports, and all other test and procedure results.

If you have any questions, please feel free to call **NAME**, our local Surveillance Supervisor, at **PHONE NUMBER**.

This information will be used for statistical purposes only, and will remain strictly confidential. Thank you very much in advance for your help in this important study.

Sincerely,

NAME

Principal Investigator

Enclosure: Release Form

E.2.4 PHYSCOV (Cover letter to physician/clinic to obtain medical records)

[date]

[doctor's office or clinic name]
[doctor's office or clinic street address]
[doctor's office or clinic city, state zip]

Dear Correspondence Clerk:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the **[institution]**, along with five other centers in the United States.

[participant] (date of birth [date of birth]), a participant in our study and your patient, reported being under your care during [year]. Enclosed you will find a release of medical information signed by [next of kin name]. We are needing medical records involving diagnoses and procedures including History and Physical, Discharge ICD-9 codes, Discharge Summary, Progress Notes, ECGs and Enzyme reports, and all other test and procedure results.

If you have any questions, please feel free to call **NAME**, our local Surveillance Supervisor, at **PHONE NUMBER**.

This information will be used for statistical purposes only, and will remain strictly confidential. Thank you very much in advance for your help in this important study. Sincerely,

NAME

Principal Investigator

Enclosure: Release Form

E.2.7 MECOV (Cover letter to medical examiner (ME) to obtain ME/coroner reports)

[date]

[medical examiner name] [street address] [city, state zip]

Dear [medical examiner name]:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the [institution] along with five other centers in the United States.

We are needing information on [participant], who died on [date of death], and whose death was listed as a Medical Examiner case. MESA requests a copy of the Medical Examiner's report. A consent form signed by his/her next of kin is enclosed.

This information will be used for statistical purposes only, and will remain strictly confidential. If you have any questions, please feel free to call **NAME**, our local Surveillance Supervisor, at **PHONE NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME

Principal Investigator

Enclosure: Release Form

E.2.8 POCERT (PO cover letter to physician signing death certificate)

[date]

[physician name] [street address] [city, state zip]

Dear [physician name]:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the [institution] along with five other centers in the United States.

We are needing information on [participant], who died on [date of death], and whose death certificate you signed on [date]. The information is needed to supplement the death certificate in assigning a cause of death. Could you or your nurse take a few moments to provide from your records the answers to the questions on the enclosed form?

This information will be used for statistical purposes only, and will remain strictly confidential. Of course, your participation is entirely voluntary, and, if you choose to not complete and return this form, it will in no way affect any relationship you may have with this institution. If you have any questions, please feel free to call me collect, at **PHONE NUMBER**, or our local Surveillance Supervisor, **NAME**, at **PHONE NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME

Principal Investigator

Enclosure: Physician Questionnaire

POATND (PO cover letter to attending physician of decedent) E.2.9

[date]

[physician name] [street address] [city, state zip]

Dear [physician name]:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the [institution] along with five other centers in the United States.

We are needing information on [participant], who died on [date of death], and who, according to the family, was your patient. The information is needed to supplement the death certificate in assigning a cause of death. Could you or your nurse take a few moments to provide from your records the answers to the questions on the enclosed?

This information will be used for statistical purposes only, and will remain strictly confidential. Of course, your participation is entirely voluntary, and, if you choose to not complete and return this form, it will in no way affect any relationship you may have with this institution. If you have any questions, please feel free to call me collect, at PHONE NUMBER, or our local Surveillance Supervisor, NAME, at PHONE **NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME

Principal Investigator

Enclosure: Physician Questionnaire

E.2.10 PQCLIN (PQ cover letter to medical clinic of decedent)

[date]

[doctor's office or clinic name] [doctor's office or clinic street address] [doctor's office or clinic city, state zip]

Dear [physician name]:

I am writing on behalf of the Multi-Ethnic Study of Atherosclerosis (MESA), an epidemiologic project of the [institution] along with five other centers in the United States.

We are needing information on [participant], who died on [date of death], and who, according to the family, was a patient at [doctor's office or clinic name]. The information is needed to supplement the death certificate in assigning a cause of death. Could you or your nurse take a few moments to provide from your records the answers to the questions on the enclosed form?

This information will be used for statistical purposes only, and will remain strictly confidential. Of course, your participation is entirely voluntary, and, if you choose to not complete and return this form, it will in no way affect any relationship you may have with this institution. If you have any questions, please feel free to call me collect, at **PHONE NUMBER**, or our local Surveillance Supervisor, **NAME**, at **PHONE NUMBER**. Thank you very much in advance for your kind assistance and consideration of this request.

Sincerely,

NAME

Principal Investigator

Enclosure: Physician Questionnaire