

PARTICIPANT INFORMATION FORM

We would like to learn a little more about you. We will not use your name with this information. If you do not want to answer a question, you can skip it and move to the next item. All of your answers will be kept confidential. **DO NOT WRITE YOUR NAME ON ANY PART OF THIS FORM.** Please let us know if you have any questions.

1. Are you...?

- Male
 Female

2. What is your current age?

- 20 - 29
 30 - 39
 40 - 49
 50 - 59
 60 - 69
 70

3. What is your ethnicity?

- Hispanic or Latino
 Not Hispanic or Latino

4. What is your race? (Check all that apply)

- White
 Black or African-American
 Asian
 Native Hawaiian/Pacific Islander
 American Indian/Alaska Native

4. What is your connection with the Patient Navigator Program?

- Health care provider within clinic system →
 Health care provider outside of clinic system →
 Social service support provider within clinic system
 Social service support provider outside of clinic system
 Administrator within clinic system
 Health education services provider
 Translator
 Clinical trials liaison
 Other (please specify): _____

Are you a:

- PCP
 Specialist
 Other type of health care provider (please specify):

5. How often have you worked with the Patient Navigator program? (Please check one)

- Less than 3 times
 Between 3 - 6 times
 More than 6 times
 I don't know/I'm not sure

THANKS FOR YOUR HELP!