OMB #: 0925-XXXX
Expiration date: XX/XX/20XX

Public reporting for this collection of information is estimated to average 5 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.

Case Tracking Form

Interviewer Initials (ID) and Name ☐☐☐ ____________________

Hospital Name: __________________________

Patient (Study Subject) Name (Last, First)	Study Subject ID Label	Patient (Study Subject) Hospital ID Number	Date Informed Consent Obtained dd/mm/yyyy	Comp Paid ☑=Y	CAPI Complete ☑=Y	Buccal Cell Collection & Delivery ☑=Y ☒=NA	Blood Collection & Delivery ☑=Y ☒=NA	Pathology Tissue Requested ☑=Y	Pathology Slides & Vials Received ☑=Y ☒=NA	Pathology Slides & Vials Transferred to SC ☑=Y ☒=NA	Consent &Comp Forms Scanned ☑=Y	Admission Report Scanned ☑=Y ☒=NA	Discharge Summary Scanned ☑=Y ☒=NA	CT, MRI, Admission CBC & Standard Tests* Write in each test scanned	Pathology Reports Scanned ☑=Y ☒=NA	Enrollment Date of Control for this Case dd/mm/yyy	Subject ID Number of Control that is Matched to Case (write in ID Number)
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐	☐	☐	☐		☐		AS _____
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐	☐	☐	☐		☐		AS _____
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐	☐	☐	☐		☐		AS _____
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐	☐	☐	☐		☐		AS _____

*CT, MRI, Admission CBC & Standard Tests (e.g., liver function, renal function) viral tests for hepatitis and MRI, flow cytometry, bone marrow studies, nuclear scans, etc. IF ANY OF LISTED TEST ABOVE IS UNAVAILABEL, for instance, MRI test, please write in "No MRI test found". **☑=Yes, ☒=NA(not available), ☒=N(No); ☐=Nothing has been done. [R/C]=if NA was checked, please circle Ⓡ=Patient Refused or ©=Could not collect

OMB #: 0925-XXXX
Expiration date: XX/XX/20XX

Public reporting for this collection of information is estimated to average 15 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.

Control Selection Record

1. Characteristics of Case Requiring a Matching Control:

		Control Matching Criteria:
Case Subject ID:	AS-☐☐☐☐☐	
a) Gender:	M ☐ F ☐	Same gender
b) Date of Birth/Age:	____________	Within +/- 5 years of age
c) Hospital:	____________	From the same hospital as the case
d) Enrollment Date:	____________ (dd/mm/yyyy):	Within +3 months of case enrollment
e) Area of Residence:	____________	
f) Resident of Core Geographic Region for at least 15 years?	Yes ☐ No ☐	

2. Approach used to select a potential control for the case identified above.

   a) Specify control disease category selected to identify potential controls (check one):

   - ☐ Injuries
   - ☐ Diseases of the circulatory system
   - ☐ Diseases of the digestive system
   - ☐ Diseases of the genitourinary system
   - ☐ Diseases of the central nervous system and sense organs

   b) Specify admission lists reviewed to identify potential controls:

   ____________________ ____________________

   ____________________ ____________________

   ____________________ ____________________

c) How many potential controls were identified who match the characteristics of the case identified above: N= ________

d) Fill in table using data on these potential controls from medical records

Name	Age	Sex	Disease	Geographic Region of Current Residence	Date and time Identified (dd/mm/yyyy); (am or pm)
1)					
2)					
3)					
4)					
5)					
6)					
7)					
8)					
9)					
10)					
11)					
12)					

DO NOT PRE-LABEL

Subject ID
(Affix label here)

Control Subject ID

e) Describe how a specific potential control subject was randomly selected to approach for enrollment ____________

____

____

____

f) Names and outcome of first (and if needed, because of being ineligible or refusal) subsequent potential control subject selected to approach as the matched control for case indentified above:

Name	**Date and Time Approached** (dd/mm/yyyy; hour:min)	**Enrolled?: Yes/No**
1)		
2)		
3)		

g) Additional control eligibility criteria to be determined based on responses to screening questions:

- No history of lymphoma.
- Having lived within the study center's core geographic region at some time for at least 15 years.

h) Following enrollment, paste selected control's Subject ID label in the upper right corner above, and on front page of form.

OMB #: 0925-XXXX
Expiration date: XX/XX/20XX

Public reporting for this collection of information is estimated to average 5 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.

Control Tracking Form

Interviewer Initials (ID) and Name ☐☐☐ ____________________ Hospital Name: __________________________

Patient (Study Subject) Name (Last, First)	Study Subject ID label	Patient (Study Subject) Hospital ID Number	Date Informed Consent Obtained	Comp Paid	CAPI Complete	Buccal Cell Collection & Delivery	Blood Collection & Delivery	Consent & Comp Forms Scanned	Admission Report Scanned	Discharge Summary Scanned	CT, MRI, Admission CBC & Standard Tests*	Name of Case that Control is Matched to	Subject ID Number of Case that Control is Matched to
			dd/mm/yyyy	☑=Y	☑=Y	☑=Y ☒=NA	☑=Y ☒=NA	☑=Y	☑=Y ☒=NA	☑=Y ☒=NA	Write in each test scanned		Write in ID Number
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐			AS _____
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐			AS _____
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐			AS _____
				☐	☐	☐ [R/C]	☐ [R/C]	☐	☐	☐			AS _____

*CT, MRI, Admission CBC & Standard Tests (e.g., liver function, renal function) viral tests for hepatitis and MRI, flow cytometry, bone marrow studies, nuclear scans, etc. IF ANY OF LISTED TEST ABOVE IS UNAVAILABEL, for instance, MRI test, please write in "No MRI test found". **☑=Yes, ☒=Not available, ☐=Nothing has been done. [R/C]=if NA was checked, please circle ®=Patient Refused or ©=Could not collect.

OMB #: 0925-XXXX
Expiration date: XX/XX/20XX

Public reporting for this collection of information is estimated to average 5 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.

Blood Collection and Processing Form

AsiaLymph Study
Blood Collection and Processing
Page 1

Subject ID
(Affix label here)

Select hospital where specimen was collected

Hong Kong Study Center (#1)
- ☐ Queen Mary Hospital
- ☐ Queen Elizabeth Hospital
- ☐ Tuen Mun Hospital
- ☐ Princess Margaret Hospital
- ☐ Pamela Youde Eastern Hospital

Tianjin Study Center (#3)
- ☐ Tianjin Medical University Cancer Institute and Hospital
- ☐ Tianjin Medical University General Hospital
- ☐ Tianjin First Center Hospital
- ☐ Second Hospital of Tianjin Medical University
- ☐ Institute of Hematology & Blood Diseases Hospital

Chengdu Study Center (#2)
- ☐ Sichuan University Hua Xi Hospital (West China Hospital)
- ☐ Sichuan Province People's Hospital
- ☐ Sichuan Tumor Hospital

Taiwan Study Center (#4)
- ☐ Dalin Tzu Chi General Hospital
- ☐ China Medical University Hospital
- ☐ Kaohsiung Chang Gung Memorial Hospital
- ☐ Chia-Yi Christian Hospital
- ☐ Kaohsuing Medical University Hospital
- ☐ National Cheng Kung University Hospital
- ☐ Chi-mei Medical Center Hospital

Subject Information (to be completed by Interviewer)

Control ☐ Case ☐

Blood Prescreening Questions (phlebotomist to ask patient prior to blood draw)

1) When was the last time you had anything to eat or drink besides water or tea? _____ HOURS AGO
2) When was the last time you smoked? _____ HOURS AGO, or CHECK IF NON SMOKER ☐
3) Have you had any problems with a blood draw in the past? ☐ YES ☐ NO ☐ DON'T KNOW

Blood Collection Information (to be completed by phlebotomist)

Date and time of blood draw: DATE: ____ / ____ / ____ TIME: ____ : ____

Blood collected by (NAME and English Initials): _____________________________________ ☐☐☐

Tube 0021 **Collection Status**

☐ Collected ☐ Not collected

Tube 0022 **Collection Status**

☐ Collected ☐ Not collected

Tube 0023 **Collection Status**

☐ Collected ☐ Not collected

Date blood specimens or aliquots received at Study Center
(to be completed by Study Center)

☐☐ / ☐☐ / ☐☐☐☐
D D M M Y Y Y Y

Received by: ____ ☐☐☐
Name

AsiaLymph Study
Blood Collection and Processing
Page 2

Subject ID
(Affix label here)

(complete if computer/Internet access is not available)

Blood Tube Receipt

Enter Date Received at lab: ____ / ____ / ____

Enter Time Received: ____ : ____

Specimen receipted by(NAME and English Initials): ______________________________ ☐☐☐

Tube 0021 **Receipt Condition**

☐ Received OK

☐ Not received

Tube 0022 **Receipt Condition**

☐ Received OK

☐ Not received

Tube 0023 **Receipt Condition**

☐ Received OK

☐ Not received

Blood Processing

Time Aliquoted: ____ : ____

Plasma Aliquots

Sequence	Created	Sequence	Created	Sequence	Created
0211	☐	**0214**	☐	**0217**	☐
0212	☐	**0215**	☐	**0218**	☐
0213	☐	**0216**	☐	**0219**	☐

BC/RBC Aliquots

Sequence	Created	Sequence	Created	Sequence	Created
0231	☐	**0232**	☐	**0233**	☐
0234	☐				

OMB #: 0925-XXXX
Expiration date: XX/XX/20XX

Public reporting for this collection of information is estimated to average 5 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.

Buccal Cell Collection and Processing Form

AsiaLymph Study
Buccal Cell Collection and Processing

Subject ID
(Affix label here)

Select hospital where specimen was collected

Hong Kong Study Center (#1)
- ☐ Queen Mary Hospital
- ☐ Queen Elizabeth Hospital
- ☐ Tuen Mun Hospital
- ☐ Princess Margaret Hospital
- ☐ Pamela Youde Eastern Hospital

Chengdu Study Center (#2)
- ☐ Sichuan University Hua Xi Hospital (West China Hospital)
- ☐ Sichuan Province People's Hospital
- ☐ Sichuan Tumor Hospital

Tianjin Study Center (#3)
- ☐ Tianjin Medical University Cancer Institute and Hospital
- ☐ Tianjin Medical University General Hospital
- ☐ Tianjin First Center Hospital
- ☐ Second Hospital of Tianjin Medical University
- ☐ Institute of Hematology & Blood Diseases Hospital

Taiwan Study Center (#4)
- ☐ Dalin Tzu Chi General Hospital
- ☐ China Medical University Hospital
- ☐ Kaohsiung Chang Gung Memorial Hospital
- ☐ Chia-Yi Christian Hospital
- ☐ Kaohsuing Medical University Hospital
- ☐ National Cheng Kung University Hospital
- ☐ Chi-mei Medical Center Hospital

Subject Information

Control ☐ Case ☐

Buccal Cell Collection Information

Date and time of collection: DATE: ____ / ____ / ____ TIME: ____ : ____

Buccal cells collected by (NAME and English Initials): ______________________________ ☐☐☐

Cup 0011 **Collection Status**

☐ Collected ☐ Not collected

Buccal Cell Receipt and Processing (complete if computer/Internet access is not available)

Buccal Cell Collection Receipt

Enter Date Received at lab: ____ / ____ / ____

Enter Time Received: ____ : ____

Specimen receipted by(NAME and English Initials): ______________________________ ☐☐☐

Receipt Condition

☐ Received OK ☐ Not received

Buccal Cell Processing Time Aliquotted: ____ : ____

Buccal Cell Aliquots	**Sequence**	**Created**	**Sequence**	**Created**
	0101	☐	**0102**	☐

Date buccal specimens or aliquots received at Study Center (to be completed by Study Center) ☐☐ / ☐☐ / ☐☐☐☐
D D M M Y Y Y Y

Received by: ______________________________ ☐☐☐
Name

For interviewer component of the reporting form:

OMB #: 0925-XXXX
Expiration date: XX/XX/20XX

Public reporting for this collection of information is estimated to average 5 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.

Subject ID
(Affix label here)

AsiaLymph Study
Pathology Specimen Request & Tracking

Section 1: Prepared by Interviewer

Hospital Name:____________________________ **Hospital AsiaLymph ID:** ☐ ☐

Date Requested: ☐ ☐ / ☐ ☐ / ☐ ☐ ☐ ☐
D D M M Y Y Y Y

Study Subject Patient's Name ☐

Patient's Hospital / Outpatient Clinic Number ☐

Patient's Hong Kong ID Number ☐

Is patient from a referral hospital? ☐ YES ☐ NO

Referral hospital name: ____

Interviewer name: ____ ☐☐☐
Name

Section 2: Prepared by Pathologist or Delegate

Date slides cut: ☐ ☐ / ☐ ☐ / ☐ ☐ ☐ ☐
D D M M Y Y Y Y

Pathology specimen number: ☐

Pathologist: ____
Name

Unstained Slides

Number of slides cut: ________

Thick Sections (20 µ)

Section Sequence	Section Created
0341	☐
0342	☐

If no unstained slides are cut, please provide original diagnostic slides which will be returned after review

Enter number of stained slides: ________ Enter number of immunostained slides: ________

Diagnostic slides were made at: ☐ Referral Hospital ☐ Study Hospital

If original diagnostic slides are not provided, are they available for future review? ☐ YES ☐ NO

Diagnostic slides available at: ☐ Referral Hospital ☐ Study Hospital

Is frozen tissue is available? ☐ YES ☐ NO

Section 3: Prepared by Interviewer

Date slides picked up from pathology lab: ☐ ☐ / ☐ ☐ / ☐ ☐ ☐ ☐
D D M M Y Y Y Y

Date slides mailed to Pathology Center (QEH): ☐ ☐ / ☐ ☐ / ☐ ☐ ☐ ☐
D D M M Y Y Y Y