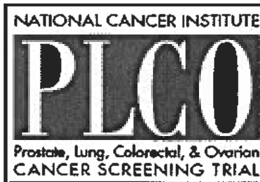


May 22, 2012

ANNUAL STUDY UPDATE

Dear

The time for completion of the Annual Study Update (ASU) and the Follow-up Locator Form (FLF) are upon us! We appreciate the time you have taken in past years to complete these and other study forms. Thank you for your most important continued participation in the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial. Enclosed are the ASU and FLF forms and a postage-paid envelope in which to return your completed forms to us.

The ASU form asks questions about your recent health and medical history. Please answer each question to the best of your ability. The contact information requested on the FLF will help us find you in future years to send you questionnaires and to notify you of study results. Please update this form with any corrections, and return it with your ASU. When you have finished completing the forms, please place them in the enclosed postage-paid envelope, and mail it to PLCO CDCC, 1600 Research Blvd. GA L60, Rockville, MD 20850.

The PLCO Central Data Collection Center (CDCC) will keep any information you give us private under the Privacy Act. Your name and identifying information will not appear in any study report. All study results will only be reported in aggregate.

Your continued participation represents a valuable contribution to the PLCO Trial, and we thank you again for your cooperation. If you have any questions or concerns please call Chris Miller, Participant Support Coordinator, at our toll-free number, (888) 886-0750.

Sincerely,

Barbara O'Brien

Barbara O'Brien, MPH
Project Director, PLCO CDCC

804104-8

PLCO Web site: http://www.cancer.gov/prevention/plco

Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

ANNUAL STUDY UPDATE and Follow-Up-Form (ASUFLF)

OMB No.: 0925-0407
Expires: XX/XX/XXXX

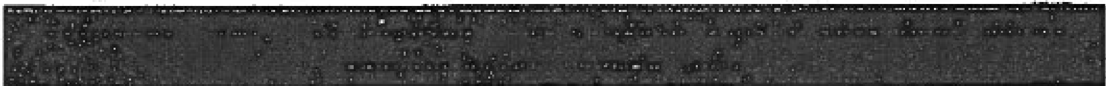
PRIVACY ACT NOTIFICATION STATEMENT

Collection of this information is authorized by The Public Health Service Act, Section 412 (42 USC 285 a-1). Rights of study participants are protected by the Privacy Act of 1974. Participation is voluntary, and there are no penalties for not participating or withdrawing from the study at any time. Refusal to participate will not affect your benefits in any way. The information collected in this study will be held in professional confidence. Names and other identifiers will be separated from information provided and will appear in any report of the study. Information provided will be combined for all study participants and reported as statistical summaries.

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN

Public reporting burden 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 mat 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 (0925-0407). Do not return the completed form to this address.

Version Date: 10/99



Participant ID: [ ]

[ ]/C
July 7,2012

Participant Name:

If Your Name (Printed Above) Is Incorrect, Please Record Your Corrected Name Below.
Corrected Name: ______

1. In the period from 09/2001 to the present, have you been diagnosed with cancer by a health care provider?
(Do not include basal-cell or squamous-cell skin cancers.)

Yes.. ☐
No.. ☐ (If no, men go to item 3; women go to item 4)

2. What type of cancer was diagnosed? (Please record all cancers diagnosed during this period except basal-cell and squamous-cell skin cancers.)

Type/Site of Cancer (breast,lung,etc)	Date of Diagnosis (Month / Day / Year)	Hospital or Clinic Where Diagnosed
______	☐☐/☐☐/☐☐	______
______	☐☐/☐☐/☐☐	______
______	☐☐/☐☐/☐☐	______

What is the name, phone# and address of the physician who diagnosed the most recent cancer?

Name: ______ Phone: (☐☐☐)-☐☐☐ -☐☐☐☐

Address: ______

3. FOR MEN ONLY: In the period from 09/2001 to present, have you taken the medication Proscar or Propecia (Finasteride)? Yes.. ☐ No.. ☐

4. Today's date: .... ☐☐/☐☐/☐☐
Month Day Year

5. Who completed this questionnaire? (Please check one.)

☐ Study Participant ☐ Spouse ☐ Someone else (Specify)

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|
Relationship

6. Comments: ______

Thank you for completing this questionnaire. Please return this form in the enclosed envelope.

Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial
FOLLOW-UP LOCATOR FORM

Participant ID: 804104-8
Study Year: T16 / C

May 22, 2012

Today's Date: / /

Please review the information printed in the left column below to make sure it is correct.
If the information in the left column is correct, check the 'OK' box. Make any additions or corrections in the right column.

	OK	
FULL NAME:	OK ☐	**FULL NAME:**
OTHER LAST NAMES:	OK ☐	**OTHER LAST NAMES:**
NICKNAME/PREFERRED NAME:	OK ☐	**NICKNAME / PREFERRED NAME:**
MAIDEN NAME:	OK ☐	**MAIDEN NAME:**
DATE OF BIRTH:	OK ☐	**DATE OF BIRTH:**
CURRENT HOME ADDRESS:	OK ☐	**HOME ADDRESS/PHONES:**
Home Phone:		**Home Phone:**
Work Phone:	**Extension**	**Work Phone:** **Ext:**
Cell Phone:		**Cell Phone:**
Email Address:		**Email Address:**
VACATION HOME/OTHER RESIDENCE: 2095 ROYAL OAK AVE W4914 ED SEVERSON RD London, England	OK ☐	**VACATION/OTHER ADDRESS/PHONE:**
Phone: (414)427-8614		**Phone:**
Time of Year:		**Time of Year:**

ADULT HOUSEHOLD MEMBERS:

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name: [redacted]
Relationship: Spouse OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

ADULT HOUSEHOLD MEMBERS:

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

Name: ______
Relationship: ______

PRIMARY CARE PHYSICIAN/CLINIC:

Allen M. Golden
333 Medical Rd
333 Professional Dr
City CO 00000

Phone: (000)000-0000
Fax: 000
Physician Type: Primary Doctor

OK ☐

Solomon Raymond Fife
710 18th St
721 W Jackson St
Smithfield PA 15219

Phone: (414)492-6310
Fax:
Physician Type: Primary Doctor

OK ☐

Anacletus Jacob Agnello
Po Box 107
12046 Cty Tr V
Gary PA 15213

Phone: (414)879-8111
Fax:
Physician Type: Primary Doctor

OK ☐

Anzy Petro Agar
6587 Deer Path Rd
N5387 Willow Rd
Mckeesport PA 15963

Phone: (414)526-2386
Fax:
Physician Type: Primary Doctor

OK ☐

Angeline Peter Adrian
500 Water St
1220 Township Ave
Puerto Rico PA 15235

Phone: (414)713-7975
Fax:
Physician Type: Primary Doctor

OK ☐

Annetta Algart Adametz
Continental Manor
5044 N Biron Dr
Jenner Twp. Somerset Co. PA 15135

Phone: (414)913-2769
Fax:
Physician Type: Primary Doctor

OK ☐

Alverda Jeanine Acton
21897 Spirit Lk Rd W
413 Main
Louisville PA 15143

Phone: (414)547-6350
Fax:

OK ☐

PRIMARY CARE PHYSICIAN/CLINIC:

Phone ________
Fax: ________
Physician Type: ________

Phone ________
Fax: ________
Physician Type: ________

Phone ________
Fax: ________
Physician Type: ________

Phone ________
Fax: ________
Physician Type: ________

Phone ________
Fax: ________
Physician Type: ________

Phone ________
Fax: ________
Physician Type: ________

Phone ________
Fax: ________

PRIMARY CARE PHYSICIAN/CLINIC:		**PRIMARY CARE PHYSICIAN/CLINIC:**
Physician Type: Primary Doctor		**Physician Type:**
Aldo Georgine Acheson N15318 Cty Rd O 3811 Griffith Ave Farrel PA 16117	OK ☐	
Phone: (414)863-8579 **Fax:** **Physician Type:** Primary Doctor		**Phone** **Fax:** **Physician Type:**
Ahmed Vincent Abbruzzese 5554 Easy St 663 S Waupaca Apt 5 Juniata PA 15650	OK ☐	
Phone: (414)609-9902 **Fax:** **Physician Type:** Primary Doctor		**Phone** **Fax:** **Physician Type:**
Aldo Walter Abbondanza Po Box 394 930 16th St N Gibsonia PA 15226	OK ☐	
Phone: (414)986-7058 **Fax:** **Physician Type:** Primary Doctor		**Phone** **Fax:** **Physician Type:**
Al Viola Adam 1420 Woodbine Rt 1, Box 304 Shreveport AK	OK ☐	
Phone: (414)299-8321 **Fax:** **Physician Type:** Primary Doctor		**Phone** **Fax:** **Physician Type:**

In the past, you provided us with the names and addresses of the following people who could give us your new address if you move. It is helpful for us to get the names of people who do not live with you. Please confirm that these people are the best contacts for you.

CONTACTS:

Phone 1: 303-1537
Phone 2:
Email Address:
Relationship: Son

OK ☐

CONTACTS:

Phone 1: ____ **Type:** ____
Phone 2: ____ **Type:** ____
Email Address: ____
Relationship: ____

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ____ **Type:** ____
Phone 2: ____ **Type:** ____
Email Address: ____
Relationship: ____

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ____ **Type:** ____
Phone 2: ____ **Type:** ____
Email Address: ____
Relationship: ____

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ____ **Type:** ____
Phone 2: ____ **Type:** ____
Email Address: ____
Relationship: ____

Phone 1:
Phone 2:
Email Address:
Relationship: Daughter

OK ☐

Phone 1: ____ **Type:** ____
Phone 2: ____ **Type:** ____
Email Address: ____
Relationship: ____

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ____ **Type:** ____
Phone 2: ____ **Type:** ____
Email Address: ____
Relationship: ____

In the past, you provided us with the names and addresses of the following people who could give us your new address if you move. It is helpful for us to get the names of people who do not live with you. Please confirm that these people are the best contacts for you.

CONTACTS:		**CONTACTS:**
	OK ☐	
Phone 1:		**Phone 1:** ______ **Type:** ______
Phone 2:		**Phone 2:** ______ **Type:** ______
Email Address:		**Email Address:** ______
Relationship:		**Relationship:** ______
	OK ☐	
Phone 1:		**Phone 1:** ______ **Type:** ______
Phone 2:		**Phone 2:** ______ **Type:** ______
Email Address:		**Email Address:** ______
Relationship:		**Relationship:** ______
	OK ☐	
Phone 1:		**Phone 1:** ______ **Type:** ______
Phone 2:		**Phone 2:** ______ **Type:** ______
Email Address:		**Email Address:** ______
Relationship:		**Relationship:** ______

Thank you for completing this questionnaire. Please return this form in the enclosed envelope.