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OMB#: 0925-0584
Exp. xx/xx/xxxx

HCHS/SOL Visit 2 Participant Safety Screening Form

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: PSE
VERSION: 1, 12/10/2013

Contact Occasion

0	2
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SEQ #

0	1
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ADMINISTRATIVE INFORMATION

0a. Completion Date (mm/dd/yyyy):

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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0b. Staff ID:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Instructions: This safety screening form must be completed before the participant can have their Baseline Examination either during a reminder phone call for the clinic visit, or immediately prior to the exam. Positive responses to Questions 2 – 6 should be noted on the Exam Itinerary Checklist for routing purposes during the visit.

NOTE TO STAFF: Use appropriate clinic scheduling script when completing this form.

A. Safety and Access Questions

1. FEMALES only: Are you pregnant? [MUJERES solamente: ¿Está embarazada?]

No 0

Yes 1 → **STOP, reschedule visit after delivery**

2. Do you need any kind of assistance reading, hearing questions, or getting on an examination table? [¿Necesita algún tipo de ayuda para leer, escuchar preguntas o para subirse a una camilla de reexaminación?]

No 0 → **GO to Question 3**

Yes 1 → **GO to Question 2a**

2a. Specify: _____

3. Do you have either a heart pacemaker or defibrillator (AICD)?

[¿Tiene un marcapaso o defibrilador (AICD por sus siglas en inglés)?]

No 0

Yes 1 → **Exclude from BIA**

4. Has a doctor or health professional ever told you that you have diabetes (high sugar in blood or urine)?

[¿Alguna vez le ha dicho un doctor que usted tiene diabetes (azúcar alta en la sangre o en la orina)?]

No 0

Yes 1 → **Exclude from OGTT**

ID NUMBER:							
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SEQ #		
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B. Echocardiography Exam Exclusion Questions

5. Did this person participate in the HCHS Echo ancillary study?
No 0
Yes 1 → **Echo Exam Exclusion**

C. Other Exclusion(s)

6. Specify condition or circumstance: _____
6a. Procedure(s)/test(s) excluded: _____
6b. Name or Staff ID authorizing this exclusion: _____

Record ALL Yes responses to Questions 2-6 on the Exam Itinerary Checklist form