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

## BIOSPECIMEN COLLECTION FROM

PARTICIPANT ID #:												LAB ID#	
FORM CODE: BIO VERSION: 1, 1/7/2014	Contact Occasion	0	2	SEQ #	0	1							

**Instructions:** This form should be completed during the participant's visit. Affix the participant ID label and the Lab ID label above. Whenever numerical responses are required, enter the number so that the last digit appears in the rightmost box. Enter leading zeroes where necessary to fill all boxes. Use a 24-hour clock for time (e.g. noon=12:00, 1pm=13:00)

**A. Safety Questions:**

1. Have you ever had a radical mastectomy or other surgery where lymph nodes were removed from your armpits?  
<sup>0</sup> No <sup>1</sup> Yes If Yes, specify in Q15 and follow precautions per QxQ instructions
2. Do you have any bleeding disorders? <sup>0</sup> No <sup>1</sup> Yes If Yes, specify in Q15; follow precautions per QxQ instructions
3. Have you ever had a graft or shunt for kidney dialysis?  
<sup>0</sup> No <sup>1</sup> Yes If Yes, specify in Q15; exclude from OGTT and follow precautions per QxQ instructions
4. Confirm/ask per Safety Form: Has diabetes <sup>0</sup> No <sup>1</sup> Yes If Yes, exclude from OGTT; go to Q7
5. Have you had part of your stomach or intestines removed? <sup>0</sup> No <sup>1</sup> Yes If Yes, exclude from OGTT; go to Q7
6. Glucose meter reading    If above 150 mg/dL exclude from OGTT; if above 200 mg/dL also go to Q6a, 6b
  - 6a. Hyperglycemia symptoms <sup>0</sup> No <sup>1</sup> Yes If symptoms present refer for urgent care
  - 6b. Ketone dipstick <sup>1</sup> Not Applicable <sup>2</sup> Negative <sup>3</sup> Positive If Positive refer for urgent care

**B. Fasting Blood Collection Information:**

7. On which day did you last eat or drink anything except water: today, yesterday, or the day before yesterday?  
<sup>1</sup> Today ..... <sup>2</sup> Yesterday <sup>3</sup> Before Yesterday
8. And at what time was that?   :    
 h h : m m If fasting is less than 8 hrs, exclude from OGTT  
 (24-hour)

**C. Blood Collection:**

9. Date of blood collection:   /   /      
 m m / d d / y y y y
10. Collection time:   :    
 h h : m m (24-hour)
11. Was fasting blood collected before the glucola/snack? <sup>0</sup> No <sup>1</sup> Yes
12. Number of venipuncture attempts:
13. Any blood drawing incidents or problems? ..... <sup>0</sup> No <sup>1</sup> Yes If Yes, specify in Q14 and/or Q15

14. Blood drawing incidents: Document problems with venipuncture in this table. Place an "X" in box(es) corresponding to the tubes in which the blood drawing problem(s) occurred. If a problem other than those listed occurred, use Item 15.

	Tube Number							
	1	2	3	4	5	6	7	8
a. Sample not drawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Partial sample drawn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Tourniquet reapplied	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Fist clenching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Needle movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Participant reclining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. If any other blood drawing problems not listed above (e.g., fasting status, etc.), describe incident or problem here:

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16. Phlebotomist's code number:

**D. Blood Processing:**

17. Time at which tubes 4 - 7 were centrifuged:  :   
h h : m m (24-hour)

18. Time at which tubes 1-2 were centrifuged:  :   
h h : m m (24-hour)

19. Time at which aliquot tray 1 vials were placed in freezer:  :   
h h : m m (24-hour)

20. Blood Processor's code number:

21. Any blood processing incidents or problems? <sup>0</sup> No <sup>1</sup> Yes **If yes, specify in Q21 and/or Q22**

22. Blood processing incidents: Document problems with the processing of specimens in this table. Place an "X" in box(es) corresponding to tubes in which the processing problem(s) occurred. If a problem other than those listed occurred, use Item 23.

	Tube Number							
	1	2	3	4	5	6	7	8
a. Broken tube	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Sample re-centrifuged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Clotted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Hemolyzed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Lipemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Comments on blood processing, urine collection/processing, and OGTT:

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24. Was a post-glucola sample collected?: <sup>0</sup> No <sup>1</sup> Yes

25. Time glucola given:  :   
h h : m m (24-hour)

26. Time of collection of post-glucola samples:  :   
h h : m m (24-hour)

27. Blood Processor's code number for post-glucose load samples:

**E. Urine Sample**

28. Was a urine sample collected? <sup>0</sup> No <sup>1</sup> Yes

29. Date of urine sample: / /   
m m / d d / y y y y

30. Time urine sample collected:  :  (24-hour)  
h h : m m

31. Time urine sample was processed:  :   
h h : m m (24-hour)

32. Urine processor's code #: