

OMB #: 0925-0654

Expiration date: 09/30/2012

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 (0925-0654). 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	Comp Paid <input type="checkbox"/> =Y <input type="checkbox"/> =N	CAPI Complete <input type="checkbox"/> =Y <input type="checkbox"/> =N	Buccal Cell Collection & Delivery	Blood Collection & Delivery	Pathology Tissue Requested	Pathology Slides & Vials Received	Pathology Slides & Vials Transferred to SC	Consent & Comp Forms Scanned	Admission Report Scanned	Discharge Summary Scanned	CT, MRI, Admission CBC & Standard Tests*	Pathology Reports Scanned	Enrollment Date of Control for this Case	Subject ID Number of Control that is Matched to Case (write in ID Number)
			dd/mm/yy			<input type="checkbox"/> =Y <input type="checkbox"/> =N	<input type="checkbox"/> =Y <input type="checkbox"/> =N	<input type="checkbox"/> =Y <input type="checkbox"/> =N	<input type="checkbox"/> =Y <input type="checkbox"/> =N	<input type="checkbox"/> =Y <input type="checkbox"/> =N	<input type="checkbox"/> =Y <input type="checkbox"/> =N	<input type="checkbox"/> =Y <input type="checkbox"/> =N	<input type="checkbox"/> =Y <input type="checkbox"/> =N		<input type="checkbox"/> =Y <input type="checkbox"/> =N	Write in each test scanned	
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		AS _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		AS _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		AS _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>		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 UNAVAILABLE, 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

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Control Selection Record

Control Selection Record

1. Characteristics of Case Requiring a Matching Control:

Control Matching Criteria:

Case Subject ID:

AS-

a) Gender:

M F

b) Date of Birth/Age:

c) Hospital:

d) Enrollment Date:

(dd/mm/yyyy):

e) Area of Residence:

f) Resident of Core Geographic Region for at least 15 years?

Yes No

Same gender

Within +/- 5 years of age

From the same hospital as the case

Within +3 months of case enrollment

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):

- | | |
|---|--|
| <input type="checkbox"/> Injuries | <input type="checkbox"/> Diseases of the genitourinary system |
| <input type="checkbox"/> Diseases of the circulatory system | <input type="checkbox"/> Diseases of the central nervous system and sense organs |
| <input type="checkbox"/> Diseases of the digestive system | |

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.

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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/yy	<input checked="" type="checkbox"/> =Y	<input checked="" type="checkbox"/> =Y	<input checked="" type="checkbox"/> =Y <input checked="" type="checkbox"/> =NA	<input checked="" type="checkbox"/> =Y <input checked="" type="checkbox"/> =NA	<input checked="" type="checkbox"/> =Y <input checked="" type="checkbox"/> =NA	<input checked="" type="checkbox"/> =Y <input checked="" type="checkbox"/> =NA	<input checked="" type="checkbox"/> =Y <input checked="" type="checkbox"/> =NA			
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			AS _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			AS _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			AS _____
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> R / C	<input type="checkbox"/> R / C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			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 UNAVAILABLE, 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.

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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)
Tianjin Study Center (#3)
Chengdu Study Center (#2)
Taiwan Study Center (#4)
List of hospitals with checkboxes for selection.

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 received 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	<input type="checkbox"/>	0214	<input type="checkbox"/>	0217	<input type="checkbox"/>
0212	<input type="checkbox"/>	0215	<input type="checkbox"/>	0218	<input type="checkbox"/>
0213	<input type="checkbox"/>	0216	<input type="checkbox"/>	0219	<input type="checkbox"/>

BC/RBC Aliquots

Sequence	Created	Sequence	Created	Sequence	Created
0231	<input type="checkbox"/>	0232	<input type="checkbox"/>	0233	<input type="checkbox"/>
0234	<input type="checkbox"/>				

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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) <input type="checkbox"/> Queen Mary Hospital <input type="checkbox"/> Queen Elizabeth Hospital <input type="checkbox"/> Tuen Mun Hospital <input type="checkbox"/> Princess Margaret Hospital <input type="checkbox"/> Pamela Youde Eastern Hospital	Tianjin Study Center (#3) <input type="checkbox"/> Tianjin Medical University Cancer Institute and Hospital <input type="checkbox"/> Tianjin Medical University General Hospital <input type="checkbox"/> Tianjin First Center Hospital <input type="checkbox"/> Second Hospital of Tianjin Medical University <input type="checkbox"/> Institute of Hematology & Blood Diseases Hospital
Chengdu Study Center (#2) <input type="checkbox"/> Sichuan University Hua Xi Hospital (West China Hospital) <input type="checkbox"/> Sichuan Province People's Hospital <input type="checkbox"/> Sichuan Tumor Hospital	Taiwan Study Center (#4) <input type="checkbox"/> Dalin Tzu Chi General Hospital <input type="checkbox"/> China Medical University Hospital <input type="checkbox"/> Kaohsiung Chang Gung Memorial Hospital <input type="checkbox"/> Chia-Yi Christian Hospital <input type="checkbox"/> Kaohsiung Medical University Hospital <input type="checkbox"/> National Cheng Kung University Hospital <input type="checkbox"/> 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 received by (NAME and English Initials): _____ [][][]

Receipt Condition

Received OK Not received

Buccal Cell Processing

Time Aliquotted: ___:___

Buccal Cell Aliquots

Sequence Created

0101

Sequence Created

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:

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AsiaLymph Study
Pathology Specimen Request & Tracking

Subject ID
(Affix label here)

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

Is patient from a referral hospital? YES
 NO

Patient's Hong Kong ID Number

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	Thick Sections (20 μ)	Section Sequence	Section Created
Number of slides cut: _____		0341	<input type="checkbox"/>
		0342	<input type="checkbox"/>

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