

**Attachment D2**

**National Health and Nutrition Examination Survey (NHANES)  
Vaccination Provider Record Check  
Participant Form**

OMB no. 0920-0950  
Expires: 11/30/2016

**Assurance of confidentiality** – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

Public reporting burden of this collection of information is estimated to average 15 minutes per response for NHANES participants, 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 CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-74, Atlanta, GA 30333. ATTN: PRA (0920-0950).

**BOX 1**

**CHECK ITEM PRQ.005:**  
IF SP AGE IS >= 14 AND <= 29, CONTINUE.  
OTHERWISE, GO TO END OF SECTION.

PRQ.001 Next, we would like to ask you for the name and contact information for all health care providers, including doctors, medical offices, health clinics, hospitals, and pharmacies or drug stores, where {you/SP} may have received vaccinations. We would also like to contact the health care providers you tell us about to ask them for {your/SP's} vaccination records. The purpose of collecting vaccination records from {your/his/her} health care providers is to help better understand illnesses that can be prevented by vaccinations.

Before we contact the health care providers you tell us about, we will ask you to sign a document giving authorization for {your/SP's} health care providers to give us {your/his/her} vaccination records. Your participation is voluntary.

INTERVIEWER: REVIEW HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM, ABOUT THE VACCINATION PROVIDER RECORD CHECK, AND QUESTIONS AND ANSWERS FOR THE VACCINATION PROVIDER RECORD CHECK.

Do we have your permission to obtain vaccination records from {your/SP's} health care providers?

YES..... 1  
NO.....2 (END OF SECTION)  
DON'T KNOW.....9 (END OF SECTION)

PRQ.002 RESPONDENT MUST SIGN THE HIPAA AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION FORM BEFORE THE INTERVIEW CAN CONTINUE.

HAS RESPONDENT SIGNED THE AUTHORIZATION FORM?

YES..... 1  
NO.....2 (END OF SECTION)

PRQ.003 To do additional health research, we would like to link the vaccination records we obtain from {your/SP's} health care providers to {your/his/her} other NHANES data. May we link {your/SP's} vaccination records we obtain from {your/his/her} health care providers to {your/his/her} other NHANES data?

YES..... 1  
NO..... 2  
DON'T KNOW..... 9

PRQ.010 G/Q Since 2006, or since {you were/SP was} X years old (**calculate X as age in years in 2016 minus 10 years**), how many locations have provided vaccinations for {you/SP}? Please include hospitals, school and workplace clinics, juvenile detention centers, emergency rooms, pharmacies or drug stores, and any other clinics or doctor's offices that have provided vaccinations.

G/Q

ENTER NUMBER OF VACCINE PROVIDERS..... 1  
Zero (0)..... 0 (PRQ.020)  
REFUSED..... 77 (END OF SECTION)  
DON'T KNOW..... 99 (PRQ.020)

\_\_\_\_\_  
ENTER NUMBER OF VACCINE PROVIDERS (PRQ.030)

PRQ.020 G/Q Since 2006, or since {you were/SP was} X years old (**calculate X as age in years in 2016 minus 10 years**), how many locations have provided **primary health care** for {you/SP}? Please include the health care settings such as clinics or doctor's offices that have seen {you/him/her} for primary health care. Primary health care includes family practice doctors, internists, pediatricians, OB/GYNs, and general practitioners.

ENTER NUMBER OF PROVIDERS..... 1  
Zero (0)..... 0 (END OF SECTION)  
REFUSED..... 77 (END OF SECTION)  
DON'T KNOW..... 99 (END OF SECTION)

|\_|\_|  
ENTER NUMBER OF PROVIDERS (PRQ.040)

PRQ.030 {Before getting started on reporting the names and contact information for locations that have provided vaccinations for {you/SP}, would you take a moment to find shot records, appointment cards, or other records you may have?

We will start with the most recent location.} What is the last name of the (first/next) doctor?

INTERVIEWER INSTRUCTION: VERIFY SPELLING.

ENTER PROVIDER NAME..... 1  
REFUSED..... 77  
DON'T KNOW..... 99 (PRQ.060)

PRQ.031 LAST NAME #1: \_\_\_\_\_

PRQ.032 LAST NAME #2: \_\_\_\_\_ (PRQ.050)

CAPI INSTRUCTION: ALLOW LAST NAME #2 TO BE BLANK/NULL  
IF REFUSED FIRST PROVIDER, GO TO END OF SECTION.  
IF REFUSED SUBSEQUENT PROVIDERS, GO TO PRQ.140.  
DISPLAY TEXT IN { } FOR FIRST PROVIDER. SUBSEQUENT PROVIDERS, DO NOT DISPLAY.

PRQ.040 {Before getting started on reporting the names and contact information for (your/SP's) primary health care providers, would you take a moment to find shot records, appointment cards, or other records you may have?

We will start with the most recent location. What is the last name of the (first/next) doctor?

INTERVIEWER INSTRUCTION: VERIFY SPELLING.

ENTER PROVIDER NAME..... 1  
REFUSED..... 77 (END OF SECTION)  
DON'T KNOW..... 99 (PRQ.060)

PRQ.041 LAST NAME #1: \_\_\_\_\_

PRQ.042 LAST NAME #2: \_\_\_\_\_ (PRQ.050)

CAPI INSTRUCTION: ALLOW LAST NAME #2 TO BE BLANK/NULL  
IF REFUSED FIRST PROVIDER, GO TO END OF SECTION.  
IF REFUSED SUBSEQUENT PROVIDERS, GO TO PRQ.140.  
DISPLAY TEXT IN { } FOR FIRST PROVIDER. SUBSEQUENT PROVIDERS, DO NOT DISPLAY.

PRQ.050 What is the doctor's first name?

INTERVIEWER INSTRUCTION: VERIFY SPELLING.

ENTER DOCTOR'S FIRST NAME..... 1  
REFUSED..... 77 (PRQ.060)  
DON'T KNOW..... 99 (PRQ.060)

FIRST NAME: \_\_\_\_\_

PRQ.060 Please tell me the name of the office, clinic, or other location.

\_\_\_\_\_  
ENTER OFFICE OR CLINIC NAME  
REFUSED..... 77 (PRQ.070)  
DON'T KNOW..... 99 (PRQ.070)

PRQ.070 What is the street address of the office, clinic, or other location?

\_\_\_\_\_

a. ENTER STREET NUMBER      b. ENTER STREET NAME

REFUSED..... 7      REFUSED..... 7  
DON'T KNOW..... 9      DON'T KNOW..... 9

PRQ.080 Is there a suite, floor or room number?

\_\_\_\_\_

ENTER SUITE, FLOOR OR ROOM NUMBER

REFUSED..... 77 (PRQ.090)  
DON'T KNOW..... 99 (PRQ.090)

CAPI INSTRUCTION: ALLOW SUITE, FLOOR OR ROOM NUMBER TO BE BLANK.

PRQ.090 What is the zip code?

\_\_\_\_\_

ENTER ZIP CODE

REFUSED..... 77 (PRQ.100)  
DON'T KNOW..... 99 (PRQ.100)

PRQ.100 What city is that in?

\_\_\_\_\_

ENTER CITY

REFUSED..... 77 (PRQ.110)  
DON'T KNOW..... 99 (PRQ.110)

PRQ.110 What state is that in?

|\_|\_|

ENTER TWO LETTER STATE ABBREVIATION TO START THE LOOKUP. SELECT STATE FROM CAPI STATE LIST. PRESS ENTER TO ACCEPT THE SELECTION.

SELECTION REFUSED..... 77 (PRQ.120)

DON'T KNOW..... 99 (PRQ.120)

CAPI INSTRUCTION:

DISPLAY FIPS STATE LIST. INTERVIEWER SHOULD ONLY BE ABLE TO SELECT 1 STATE FROM THE LIST. DON'T KNOW AND REFUSED SHOULD BE VALID OPTIONS. THE STATE LOOKUP IN THE SP AND FAMILY QUESTIONNAIRES SHOULD WORK EXACTLY THE SAME. SAVE STATE LOOKUP NAME AS PRQ.112 AND STATE FIPS LOOKUP CODE AS PRQ.115.

PRQ.120 What is their telephone number?

|\_|

PRQ.120

ENTER AREA CODE

|\_|\_|\_| - |\_|\_|\_|\_|\_|

PRQ.121

ENTER TELEPHONE NUMBER

|\_|\_|\_|\_|

PRQ.122

ENTER EXTENSION

REFUSED..... 777 (PRQ.130)

DON'T KNOW..... 999 (PRQ.130)

REFUSED.....7777777

DON'T KNOW..... 9999

REFUSED..... 7777

DON'T KNOW..... 9999

PRQ.130 ARE THERE ANY OTHER HEALTH CARE PROVIDERS?

OR ASK RESPONDENT:

(Are there any other health care providers?)

YES..... 1

NO..... 2

REFUSED..... 77

DON'T KNOW..... 99

CAPI INSTRUCTION:

SOFT EDIT: IF NUMBER OF PROVIDERS ENTERED DOES NOT EQUAL PRQ.010 OR PRQ.020, DISPLAY "Earlier you said you had seen {x} providers but we have entered information for {x}. Is that correct?"

**BOX 2**

**CHECK ITEM PRQ.135:**

ASK PRQ.030 – PRQ.120 FOR NEXT PROVIDER (CODE 1 IN PRQ.130). IF NO, DK OR RF NEXT PROVIDER (CODE 2, DK, RF IN PRQ.130), CONTINUE WITH PRQ.140.

PRQ.140 REVIEW TOTAL NUMBER OF PROVIDERS AND THEIR CONTACT INFORMATION WITH RESPONDENT.

I have listed {TOTAL NUMBER} health care provider{s} for {you/SP}: {PROVIDER(S) NAME AND ADDRESS}

PRESS ENTER TO CONTINUE.

CAPI INSTRUCTION:

DISPLAY NUMBER OF PROVIDERS FROM PRQ.010 OR PRQ.020. DISPLAY NUMBER ON SCREEN.

DISPLAY LIST OF PROVIDER NAMES AND CONTACT INFORMATION FROM PRQ.030-PRQ.120.

DISPLAY PROVIDER NAMES AND CONTACT INFORMATION ON SCREEN.