

Pease Study Blood Draw and Urine Collection Form

Form Approved
OMB No. 0923-XXXX
Exp. Date xx/xx/201x

ATSDR estimates the average public reporting burden for this collection of information as 10 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0923-xxxx).

Study ID No.: | _____ |

You were asked to collect a first morning void urine sample when you got up today.

1. Did you bring it today? Yes No

1a. [IF NO] Can you give us a sample now? Yes No

2. Result of the urine collection (mark one) Volume

Complete (at least 10-mL)

Partial 2a. (_____ -mL)

Unable to collect

Before we can take [your/your child's] blood we need to ask you a few questions on whether [you/your child] can provide a blood sample.

3. [Do you/Does your child] have hemophilia? Yes No

4. [Have you/Has your child] received any chemotherapy in the last four weeks? Yes No

5. [Do you/Does your child] have active sores, disease, or other problem on the arm/shoulder that could prevent us from taking a blood sample*? Yes No

* This may include gauze dressings, casts, edema, paralysis, tubes, open sores or wounds, withered arms or limbs missing, damaged, sclerosed or occluded veins, allergies to cleansing reagents, burned or scarred tissue, shunt or intravenous lines on both arms. Please check and review all with the participant.

[IF THE ADULT/PARENT OR GUARDIAN RESPONDED 'YES' TO ANY OF THE ABOVE QUESTIONS, THE PARTICIPANT SHOULD BE EXCLUDED FROM THE BLOOD DRAW. PLEASE SEE STUDY COORDINATOR IMMEDIATELY.]

SENIOR SUPERVISING NURSE WILL MAKE THE DECISION WHETHER A PARTICIPANT WITH ANY TYPE OF SHOULDER LESIONS CAN SAFELY PROVIDE A BLOOD SAMPLE]

We also want to ask you a few more questions as a precaution.

6. [Are you/Is your child] on blood thinning medication? Yes No

7. Are you on diabetes medication or insulin? Yes No

8. Tell me the last time you ate. Was it less than eight hours ago? Yes No

8a. [IF YES] How long ago did you eat? |_|_|:|_|_| (hours and minutes)

8b. . . . and what did you eat? |-----|

[IF THE PARTICIPANT ANSWERED 'YES' TO ANY OF THE ABOVE QUESTIONS PLEASE SEE STUDY COORDINATOR AND SUPERVISING NURSE TO MAKE SURE THEY CAN SAFELY PROVIDE BLOOD SAMPLE]

9. Result of the Blood Draw (mark one) Volume

Complete (125-mL)

Partial 7a. (_____-mL)

Unable to collect

9a. Date: |_|_|/|_|_|/|_|_| 9b. Time: |_|_|:|_|_| AM PM

9c. Code Partial/Inability to Collect (circle one)

Reason for partial or inability to collect blood:

1. Pregnant
2. Medical (e.g. patient frail, weak, lost consciousness)
3. Refused
4. Other (describe) _____

10. Interviewer/Phlebotomy Comment:

NOTES: Care should be used in drawing blood from all subjects. Common adverse effects include bruising, bleeding, and fainting. Please ask all participants whether they prefer to lie down to have blood drawn.

Ask everyone if they tend to faint when giving blood. Suggest they sit down for five minutes after giving blood.

Fasting diabetic participants who use insulin will be given priority appointments for their blood draw.

Light snacks will be provided following blood collection.

See Protocol **Attachment 14 (Manual of Operations)** for further details on collecting blood samples.