Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

Attachment 3a

Ovarian Cancer Survivorship Survey

CDC estimates the average public reporting burden for this collection of information as 50 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 (0920-XXXX).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Ovarian CANCER Survivorship Survey

NORC at the UNIVERSITY of CHICAGO

Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

INTRO This survey is specifically for women who have been diagnosed with ovarian cancer. In addition to ovarian cancer, this survey is also for women who have been diagnosed with cancer of the fallopian tubes, or cancer of the primary peritoneum. For simplicity, all three of these cancers will be referred to as ovarian cancer throughout the survey.

Some women who participate in this survey will be much closer to their diagnosis and still undergoing treatment, while others may have ended treatment several years ago. Several questions will ask you to think back to when you were first diagnosed with ovarian cancer, or when you were receiving treatment. If you are currently receiving treatment, please answer these questions to the best of your ability.

Your answers will help us better understand how to help women with ovarian, fallopian tube, and primary peritoneal cancer as they are diagnosed, receive treatment, and begin to recover. Please answer all of the following questions by choosing the option that best applies to you. There are no “right” or “wrong” answers. The information that you provide will remain strictly confidential.

Your opinions are very important to us, and we appreciate your help.

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SECTION A: SCREENER

SCREENER1 Are you at least 18 years old?

- ☐ Yes
- ☐ No **[GO TO INELIGIBLE]**

SCREENER2 Have you ever been diagnosed with ovarian, fallopian tube, or primary peritoneal cancer?

- ☐ Yes
- ☐ No **[GO TO INELIGIBLE]**

SCREENER3 Have you received any treatment for your ovarian cancer?

- ☐ Yes **[GO TO CONSENT]**
- ☐ No **[GO TO INELIGIBLE]**

INELIGIBLE Thank you for your interest in this study. Unfortunately, you are not eligible to participate in the survey at this time. Thank you for your time.

Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

SECTION A1: INFORMED CONSENT

CONSENT NORC at the University of Chicago is conducting a survey sponsored by the Centers for Disease Control and Prevention. This survey is to learn about your experiences as an ovarian cancer survivor. By taking this survey, you will help us identify needs of ovarian cancer survivors in order to develop programs aimed at improving survivor health.

The survey will include questions related to your experiences, health, and well-being as an ovarian cancer survivor as well as general demographics and questions related to health and cancer in your family. The survey will take about 45 minutes to complete.

Taking the survey is your choice. Some questions may be sensitive to you. You may skip questions you do not want to answer and you can stop the survey at any time. Eligible participants will be mailed $10 at the end of the survey.

Any information you provide will be maintained in a secure manner. No one will know how you answered the questions. Only project staff will have access to the study data. The data we collect from you will be combined with data from other participants.

If you have any questions about the survey, you can call the NORC IRB Administrator toll-free at: 866-309-0542.

I have read the above information. I consent voluntarily to be a participant in this study.

- € Yes [CONTINUE TO SECTION B]
- € No [END]

END Thank you for your interest. Have a nice day.

Form Approved
OMB No. 0920-xxxx
Exp. Date xx/xx/xxxx

SECTION B: OVARIAN CANCER SYMPTOMS AND DIAGNOSIS

INTRO2 The questions in this survey will only indicate ovarian cancer, but are relevant to all 3 cancer types (ovarian, fallopian tube, or primary peritoneal cancer). The following questions are about your ovarian cancer symptoms and diagnosis.

DIAG_AGE What was your age when you were first diagnosed with ovarian cancer?

_____ Years Old

DIAG_HOW Which of the following best describes how you were first diagnosed with ovarian cancer?

- ☐ I was diagnosed as part of a routine exam, check-up, or screening test.
- ☐ I was diagnosed after seeking medical care to check on problems or symptoms I was having.
- ☐ Other, *please specify:* _____

SYMPTOM_x Did you experience any of the following symptoms that were not normal for you in the weeks or month(s) leading up to your ovarian cancer diagnosis?

	Yes	**No**
a. Vaginal bleeding or discharge from your vagina that was not normal for you	☐	☐
b. Pain or pressure in the pelvic or abdominal area (area between your stomach to between your hip bones)	☐	☐
c. Lower back pain	☐	☐
d. Bloating or stomach swelling	☐	☐
e. Feeling full quickly or difficulty eating	☐	☐
f. Change in bathroom habits, such as more frequent or urgent need to urinate and/or constipation	☐	☐

DIAG_TIME How much time passed from when you started experiencing symptoms or knew something was wrong, to when you received an ovarian cancer diagnosis?

- ☐ A week or less
- ☐ 2 weeks
- ☐ 3 weeks
- ☐ A month
- ☐ 2 months
- ☐ More than 2 months, but less than 6 months
- ☐ More than 6 months
- ☐ Didn't experience any symptoms

STAGE At what stage was your ovarian cancer diagnosed?

- ☐ Stage 1

- ◻ Stage 2
- ◻ Stage 3
- ◻ Stage 4
- ◻ Other, *please specify:* _____
- ◻ Don't know

DR_WHICH Which of the following doctors diagnosed your ovarian cancer?

- ◻ Oncologist or cancer doctor
- ◻ Gynecological oncologist (specialty oncologist)
- ◻ Surgeon
- ◻ Primary care or Internal medicine doctor
- ◻ Gynecologist
- ◻ ER doctor
- ◻ Gastroenterologist
- ◻ Other, *please specify:* _____
- ◻ Don't know

CANC_OTH Other than your ovarian cancer, have you ever been diagnosed with any other kind of cancer?

- ◻ Yes
- ◻ No **[GO TO SECTION C]**

CANC_xxxx What type of cancer and how old were you were you were diagnosed?

CANC_TYPE Cancer Type	**CANC_AGE** Age

SECTION C: OVARIAN CANCER TREATMENT

INTRO3 The following questions are about any treatment you may have received for your ovarian cancer.

SURGERY Did you receive surgery as part of your ovarian cancer treatment?

- ◻ Yes
- ◻ No **[GO TO TRTMENT_A]**

DR_SURG Which doctor performed your ovarian cancer surgery?

- ◻ Oncologist
- ◻ General Surgeon
- ◻ Gynecologist

- ◻ Gynecologic Oncologist
- ◻ Other, *please specify:* _____
- ◻ Don't know

TRAVEL_SURG Approximately how long did you travel one-way to the hospital or facility where you received surgery for your cancer?

- ◻ Less than 30 minutes
- ◻ Thirty minutes or more, but less than one hour
- ◻ One hour or more, but less than 2 hours
- ◻ Two or more hours

TRTMNT_x Did you receive any of the following cancer treatments as part of your ovarian cancer treatment?

	Yes	No	Don't know
a. Chemotherapy that was injected into a vein or through a port (also known as intravenous)	◻	◻	◻
b. Chemotherapy that was injected into the abdominal cavity (also known as intraperitoneal)	◻	◻	◻
c. Monoclonal antibody therapy – uses antibodies made in a laboratory from immune cells; given through an infusion	◻	◻	◻
d. Bevacizumab – antibody therapy used with chemotherapy to treat ovarian cancer	◻	◻	◻
e. Poly polymerase inhibitors, or PARP inhibitors – drugs that block DNA repair and may cause cancer cells to die. *Examples: Olaparib, Niraparib*	◻	◻	◻
f. Other, *please specify:* _____	◻	◻	◻

PROGRAMMER: IF ANY OF ABOVE EQUAL '1' (YES), CONTINUE TO TRAVEL_CHEMO. OTHERWISE, SKIP TO CLINICTRIAL.

TRAVEL_CHEMO How long did you travel one-way to the hospital or facility where you received chemotherapy for your cancer?

- ◻ Less than 30 minutes
- ◻ Thirty minutes or more, but less than one hour
- ◻ One hour or more, but less than 2 hours
- ◻ Two or more hours

CLINICTRIAL Clinical trials are research studies that involve people. They are designed to test the safety and effectiveness of new treatments and to compare new treatments with standard care. Often, patients in clinical trials are not told what treatment they received until the trial is over.

Were you offered or did you seek out participation in a clinical trial as part of your ovarian cancer treatment? *Only include clinical trials for drugs to treat cancer. Do not include trials for medications to treat cancer-related side effects, like nausea.*

- ☐ Yes
- ☐ No [**GO TO RECENT]**

TRIAL_PART Did you participate in a clinical trial as part of your cancer treatment?

- ☐ Yes
- ☐ No

NO_PART Were you ever denied participation or decided not to participate in a clinical trial?

- ☐ Yes
- ☐ No **[GO TO RECENT]**

REASON What was the main reason you did not enter the clinical trial?

- ☐ I did not meet the eligibility criteria.
- ☐ I refused the treatment protocol.
- ☐ I wanted to be treated elsewhere or by a different doctor.
- ☐ I wanted to know exactly what treatment I was receiving.
- ☐ Other, *please specify:* _____

RECENT How long ago was your most recent treatment for ovarian cancer?

- ☐ Currently receiving treatment
- ☐ Less than 12 months ago **[GO TO ER_EVER]**
- ☐ At least a year ago, but less than 3 years ago **[GO TO ER_EVER]**
- ☐ At least 3 years ago, but less than 5 years ago **[GO TO ER_EVER]**
- ☐ At least 5 years ago, but less than 10 years ago **[GO TO ER_EVER]**
- ☐ More than 10 years ago **[GO TO ER_EVER]**

TRTMT_CURR What treatment(s) are you currently receiving?

ER_EVER While undergoing cancer treatment, did you ever have to go to the emergency room (ER)?

- ☐ Yes

- ☐ No

EFFECTS_x Many cancer patients experience several different symptoms or side effects while undergoing treatment. These side effects can vary from mild to severe. Did you have any of the following experiences while undergoing cancer treatment?

	Yes	No
a. Had to interrupt or delay treatment	☐	☐
b. Had to stop or suspend treatment	☐	☐
c. Doctors prescribed medication to deal with side effects	☐	☐
d. Doctors changed treatment to deal with side effects	☐	☐
e. Refer you to specialists to help deal with side effects	☐	☐

RECUR Since you were first diagnosed with and treated for ovarian cancer, has a doctor ever told you that your ovarian cancer had come back, that is, that you had a cancer recurrence?

- ☐ Yes
- ☐ No **[GO TO METASTASIS]**
- ☐ Don't know **[GO TO METASTASIS]**

RECUR_AGE What was your age when your cancer came back, or recurred?

_____ Years Old

METASTASIS Since you were first diagnosed with and treated for ovarian cancer, has a doctor or other health professional told you that your ovarian cancer had spread to another part of your body, that is, that you had a metastasis?

- ☐ Yes
- ☐ No **[GO TO REMISSION]**

META_AGE What was your age when you were diagnosed with a metastasis?

_____ Years Old

REMISSION To the best of your knowledge, are you now free of cancer or been told that your cancer is in remission?

- ☐ Yes
- ☐ No
- ☐ Don't know

SECTION D: YOUR HEALTH AFTER CANCER

INTRO4 People who have received treatment for cancer often report that they continue experiencing a variety of symptoms or problems after, or even long after, they have

completed treatment. The following questions are about potential symptoms and side effects from your cancer treatment.

TXSYMPTOM_x Have you ever experienced any of the following symptoms since you received treatment for your cancer?

	Yes	No
a. Numbness, prickling or tingling in your hands or feet	☐	☐
b. Sharp, jabbing, throbbing, freezing or burning pain in your extremities	☐	☐
c. Extreme sensitivity to touch	☐	☐
d. Lack of coordination or falling	☐	☐
e. Muscle weakness in your arms and legs	☐	☐

[PROGRAMMER: IF TXSYMPTOM_A=1 OR TXSYMPTOM_B=1 OR TXSYMPTOM_C=1 OR TXSYMPTOM_D=1 OR TXSYMPTOM_E=1, CONTINUE. OTHERWISE, SKIP TO TREAT_A.]

EXPBEFORE Had you ever experienced any of these symptoms before your cancer diagnosis and treatment?

- ☐ Yes
- ☐ No

INTERFERE How much have these symptoms interfered with your everyday activities, like getting dressed, working, participating in hobbies, doing usual household activities, or sleeping?

- ☐ Very much
- ☐ Quite a bit
- ☐ A little
- ☐ Not at all

TALK_SYMP Have you talked to a doctor or other health professional about these symptoms?

- ☐ Yes
- ☐ No

TREAT_x Have you used any of the following treatments to help you address your symptoms?

	Yes	No
a. Over the counter pain relievers (like Tylenol, Aspirin, or Advil)	☐	☐
b. Prescription pain relievers	☐	☐
c. Other prescription drugs or medication	☐	☐
d. Electric nerve stimulation	☐	☐
e. Physical or Occupational therapy	☐	☐
f. Alternative treatments like acupuncture or herbal supplements	☐	☐
g. Other, *please specify:*	☐	☐

NEUROP Since you received treatment for your cancer, has a doctor or any other health care provider told you that you have neuropathy? *Neuropathy is pain numbness or discomfort caused by damage to the nerves that brings signals to and from the brain and spinal cord to other parts of the body, such as the hands and feet. Some women develop neuropathy after receiving treatment for cancer.*

- ◻ Yes
- ◻ No
- ◻ Don't know
- ◻ Diagnosed before I had cancer

SINCE_x Have you experienced any of the following since you received treatment for your cancer?

	Yes	No
a. Felt like you had to read something several times to understand it	☐	☐
b. Felt like your thinking was slow	☐	☐
c. Felt like you had to work really hard to pay attention or you would make a mistake	☐	☐
d. Had difficulty concentrating	☐	☐
e. Had a hard time remembering things	☐	☐
f. Had a hard time reading and following complex instructions (e.g. directions for a new medication)	☐	☐
g. Had difficulty planning for and keeping appointments that are not part of your weekly routine (e.g. a therapy or doctor appointment, or a social gathering with friends and family)	☐	☐
h. Had trouble managing your time to do most of your daily activities	☐	☐
i. Had difficulty learning new tasks or instructions	☐	☐
j. Had trouble recalling the name of an object when talking to someone	☐	☐

[PROGRAMMER: IF SINCE_X=1 CONTINUE. OTHERWISE, SKIP TO COGNITIVE.]

BEFORE Had you experienced any of these symptoms before your cancer diagnosis and treatment?

- ◻ Yes
- ◻ No

ACTIVITIES How much have these symptoms interfered with your everyday activities, like doing your job, reading a book, participating in hobbies, or doing usual household activities?

- ◻ Very much
- ◻ Quite a bit
- ◻ A little
- ◻ Not at all

SYMPTALK Have you talked to a doctor or other health professional about these symptoms?

- ◻ Yes
- ◻ No

COGNITIVE Since you received treatment for your cancer, has a doctor or any other health care provider told you that you had chemo-brain, chemo-fog, or were suffering from cognitive issues due to chemotherapy?

- ◻ Yes
- ◻ No

WGT_CHG Did your weight change while you were undergoing cancer treatment?

- ◻ Yes, lost weight
- ◻ Yes, gained weight
- ◻ No, weight was more or less the same

WGT_REC Since being diagnosed with cancer, has a doctor or other health professional ever recommended that you gain or lose weight?

- ◻ Yes, recommended lose weight
- ◻ Yes, recommended gain weight
- ◻ Recommended I maintain my weight
- ◻ No, haven't received any weight-related recommendations

WEIGHT About how much do you currently weigh without shoes?

_____ Pounds

HEIGHT_FT About how tall are you without shoes?
HEIGHT_IN **____ Feet ____ Inches**

PSTWK_x Please indicate the extent to which you have experienced these symptoms or problems during the past week.

During the PAST WEEK…	**Not at all**	**A little**	**Quite a bit**	**Very much**
a. Did you have abdominal pain?	☐	☐	☐	☐
b. Did you have a bloated feeling in your abdomen/stomach?	☐	☐	☐	☐
c. Did you have problems with your clothes feeling too tight?	☐	☐	☐	☐
d. Did you experience any change in bowel habits?	☐	☐	☐	☐
e. Were you troubled by passing wind/gas/flatulence?	☐	☐	☐	☐
f. Have you felt full too quickly after beginning to eat?	☐	☐	☐	☐
g. Have you had indigestion or heartburn?	☐	☐	☐	☐
h. Have you lost any hair?	☐	☐	☐	☐
i. Did food and drink taste different than usual?	☐	☐	☐	☐
j. Have you felt weak in your arms or legs?	☐	☐	☐	☐

k. Did you have aches and pains in your muscles or joints?	☐	☐	☐	☐
l. Did you have problems with hearing?	☐	☐	☐	☐
m. Did you urinate frequently?	☐	☐	☐	☐
n. Have you had skin problems (e.g. itchy, dry)?	☐	☐	☐	☐
o. Did you have hot flashes?	☐	☐	☐	☐
p. Did you have night sweats?	☐	☐	☐	☐
q. Have you felt physically less attractive as a result of your disease or treatment?	☐	☐	☐	☐
r. Have you been dissatsified with your body?	☐	☐	☐	☐
s. How much has cancer been a burden to you?	☐	☐	☐	☐
t. How much has your treatment been a burden to you?	☐	☐	☐	☐
u. Were you worried about your future health?	☐	☐	☐	☐

SECTION E: YOUR FAMILY HISTORY OF CANCER

INTRO5 The following section will ask about your family history of cancer and genetic testing.

RISK_TALK Before you were diagnosed with ovarian cancer, had you ever talked to your doctor about your family history of cancer and what it might mean for your own health and cancer risk?

- ☐ Yes
- ☐ No

FAM_OVAR Have any other women in your family, that you are related to by blood, ever been diagnosed with ovarian cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

- ☐ Yes
- ☐ No **[GO TO FAM_BREAST]**
- ☐ Don't know **[GO TO FAM_BREAST]**

OVAR_NUM How many women in your family, that you are related to by blood, have been diagnosed with ovarian cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

_____ Number of relatives

FAM_BREAST Have any other women in your family, that you are related to by blood, ever been diagnosed with breast cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

- ☐ Yes
- ☐ No **[GO TO MALE_BREAST]**
- ☐ Don't know **[GO TO MALE_BREAST]**

BREAST_NUM How many women in your family, that you are related to by blood, have been diagnosed with breast cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

_____ Number of relatives

UNDER50 How many of them were diagnosed when they were younger than age 50?

_____ Number of relatives

MALE_BREAST Have any men in your family, that you are related to by blood, ever been diagnosed with breast cancer?

- ◻ Yes
- ◻ No
- ◻ Don't know

GENETIC_REC Genetic counseling involves an in-depth discussion with a trained genetic counselor, doctor, or nurse about your family's health history and your risk for having an inherited genetic mutation. Has a doctor or other health professional ever recommended or referred you for genetic counseling for breast or ovarian cancer?

- ◻ Yes
- ◻ No

GENETIC_YN Have you ever received genetic counseling for breast or ovarian cancer risk?

- ◻ Yes
- ◻ No **[GO TO GENETIC_FAM]**
- ◻ Don't know **[GO TO GENETIC_FAM]**

GENETIC_WHEN When did you receive genetic counseling? *Please select all that apply.*

- ◻ Before I was diagnosed
- ◻ At the same time I was diagnosed
- ◻ After I was diagnosed

GENETIC_WHO From whom did you receive genetic counseling? *Please select all that apply.*

- ◻ Genetic counselor
- ◻ My regular or primary care doctor
- ◻ Nurse
- ◻ Cancer doctor or oncologist
- ◻ Gynecologist
- ◻ Other
- ◻ Don't know

GENETIC_FAM As far as you know, have any of your blood relatives received genetic counseling for breast or ovarian cancer risk?

- ◻ Yes
- ◻ No

BRCA_YN BRCA1 and BRCA2 are genes in a person's DNA that are associated with the risk of breast and ovarian cancer. There are genetic tests for mutations in BRCA1 and BRCA2, requiring a blood sample, saliva sample, or cheek swab, that can provide information about your risk for these cancers. Have you ever had a BRCA1 or BRCA2 genetic test (sometimes called BRAC analysis) for cancer risk?

- ◻ Yes
- ◻ No **[GO TO NOTEST]**
- ◻ Don't know **[GO TO NOTEST]**

BRCA_RESULTS Did the results of your BRCA1/BRCA2 test indicate that you carry a mutation that would put you at increased risk for cancer?

- ◻ Yes
- ◻ No **[GO TO BRCA_FAM]**
- ◻ Inconclusive result (often called "Variant of Unknown Significance") **[GO TO BRCA_FAM]**
- ◻ Don't know **[GO TO BRCA_FAM]**

INFLUENCE Did the results of your genetic testing influence your cancer treatment in any of the following ways?

	Yes	**No**
a. Influenced surgery – had additional ovary or both ovaries removed	☐	☐
b. Influenced surgery – had one or both breasts removed (mastectomy)	☐	☐
c. Took a PARP inhibitor (Poly polymerase inhibitors, or PARP inhibitors – drugs that block DNA repair and may cause cancer cells to die. Examples: Olaparib, Niraparib)	☐	☐
d. Other, *please specify:* _____	☐	☐

PROGRAMMER: IF BRCA_YN=1, SKIP TO BRCA_FAM.

NOTEST Why did you not receive genetic testing? *Please mark all that apply*.

- ◻ I didn't know about it
- ◻ I didn't want to
- ◻ Too expensive
- ◻ My friends and family didn't think I needed it
- ◻ I was afraid of the result
- ◻ Someone else in my family had genetic testing
- ◻ My doctor never brought it up or offered testing

- ☐ Insurance wouldn't cover it
- ☐ My doctor didn't think I needed it
- ☐ I was afraid it would affect my health insurance coverage
- ☐ Other reasons

BRCA_FAM As far as you know, have any of your blood relatives received genetic testing for mutations in BRCA1 or BRCA2 genes?

- ☐ Yes
- ☐ No
- ☐ Don't know

BRCA_DESCNT Studies show that BRCA1 and BRCA2 are more common in persons of Ashkenazi Jewish descent. Most people of Ashkenazi descent can trace their ancestry to Eastern Europe. Are you and your family of Ashkenazi Jewish descent?

- ☐ Yes
- ☐ No
- ☐ Don't know

SECTION F: INTERACTIONS WITH THE MEDICAL SYSTEM

INTRO6 Next, we will ask you some questions about your experiences interacting with the medical system, while undergoing diagnosis and treatment for cancer, including your doctors, nurses, and other hospital or health system staff.

SIDEEFFECTS_x How much do you agree or disagree with each of the following statements?

	Strongly Disagree	Disagree	Agree	Strongly Agree	Doesn't Apply
a. My doctors talked to me about possible side effects before I started my cancer treatment.	☐	☐	☐	☐	☐
b. My doctors frequently asked if I was experiencing side effects associated with my cancer treatment.	☐	☐	☐	☐	☐
c. My doctors listened when I reported treatment-related side effects.	☐	☐	☐	☐	☐
d. My doctors helped me deal with side effects from my treatment.	☐	☐	☐	☐	☐
e. My doctors gave me information on how I could manage treatment related side effects at home.	☐	☐	☐	☐	☐
f. My treatment-related side effects were well managed.	☐	☐	☐	☐	☐
g. I am satisfied with how my doctors managed my treatment-related side effects.	☐	☐	☐	☐	☐

h. I had a hard time dealing with the side effects from my cancer treatment.	☐	☐	☐	☐	☐
i. I looked for information online about how to manage my treatment-related side effects.	☐	☐	☐	☐	☐
j. My doctors were not very helpful in dealing with the side effects from my cancer treatment(s).	☐	☐	☐	☐	☐
k. I had all the support I needed in dealing with the side effects from my cancer treatment(s).	☐	☐	☐	☐	☐

SECTION G: SUPPORT AND COPING

INTRO7 The following questions are about psychological and emotional care you may have received before, during, or after your cancer diagnosis and treatment.

RELATIONS During your cancer diagnosis and treatment, did your doctor, nurse, or other health professional talk with you about how cancer may affect your emotions or relationships with other people?

- ◻ Yes
- ◻ No
- ◻ Don't know

SERVICES_x During your cancer diagnosis and treatment, did you participate in or utilize any of the
HELPFUL_x following services to help you cope psychologically or emotionally?

SERVICES			*If Yes, How helpful did you find this resource to be?*	**HELPFUL** How helpful did you find this resource to be?			
	Yes	No		Very Helpful	Somewhat Helpful	A Little Helpful	Not At All Helpful
a. Support Group	☐	☐		☐	☐	☐	☐
b. Professional Counseling	☐	☐		☐	☐	☐	☐
c. Talk to religious leaders or members of spiritual community	☐	☐		☐	☐	☐	☐
d. Talk to doctors, nurses, or other health professionals	☐	☐		☐	☐	☐	☐
e. Talk to friends and family	☐	☐		☐	☐	☐	☐
f. Yoga or other exercise	☐	☐		☐	☐	☐	☐
g. Meditation	☐	☐		☐	☐	☐	☐
h. Stress reduction or management techniques	☐	☐		☐	☐	☐	☐

i.	Social worker	☐	☐		☐	☐	☐	☐
j.	The internet to get cancer education or support, like in an online community or forum	☐	☐		☐	☐	☐	☐
k.	Camps, retreats, adventure programs or social activities that offer cancer education or support	☐	☐		☐	☐	☐	☐
l.	Other, *please specify:*	☐	☐		☐	☐	☐	☐

PROGRAMMER: IF ALL SERVICES_A THROUGH SERVICES_I = 2, CONTINUE. OTHERWISE, SKIP TO RELY_A.

NOSUPPORT Do any of the following reasons apply to why you didn't utilize any support services? *Please select all that apply.*

- ☐ I didn't know these services were available.
- ☐ I didn't want to participate in these services or activities.
- ☐ I didn't have a way of getting to these activities or services.
- ☐ I didn't think I needed to participate in these activities.
- ☐ I couldn't afford to participate in these activities.

RELY_x During cancer diagnosis and treatment, did you have people you were able to rely on to….

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Remind or help you take medications?	☐	☐	☐	☐	☐
b. Help you cook meals?	☐	☐	☐	☐	☐
c. Help you complete household chores?	☐	☐	☐	☐	☐
d. Help you run errands?	☐	☐	☐	☐	☐
e. Provide transportation?	☐	☐	☐	☐	☐
f. Help take care of children or pets?	☐	☐	☐	☐	☐
g. Help with your caregiving responsibilities, like having someone take care of a sick friend or relative that you normally care for?	☐	☐	☐	☐	☐
h. Accompany you to doctor's appointments?	☐	☐	☐	☐	☐
i. Help you complete work responsibilities?	☐	☐	☐	☐	☐
j. Help take care of important duties, such as pay bills?	☐	☐	☐	☐	☐
k. Help you financially?	☐	☐	☐	☐	☐

l. Confide in or talk to about how you were feeling or doing?	☐	☐	☐	☐	☐
m. Provide comfort or support in a time of need?	☐	☐	☐	☐	☐
n. Share your worries or fear with?	☐	☐	☐	☐	☐
o. Help you take your mind off things?	☐	☐	☐	☐	☐
p. Have a good time or do something enjoyable with?	☐	☐	☐	☐	☐

SECTION H: YOUR HEALTH INSURANCE

INTRO8 The following questions are about your health insurance coverage during your cancer diagnosis and treatment.

INSURE_YN Did you have any form of health insurance that paid for all or part of your medical care, tests, or cancer treatments?

- ▫ Yes
- ▫ No

INSURE_TYPE What kind of health insurance did you have at the time of your ovarian cancer diagnosis and treatment? *Please select all that apply*.

- ▫ Health insurance through your (or your spouse's) employer
- ▫ Private health insurance, individually purchased
- ▫ Medicare
- ▫ Medi-Gap
- ▫ Medicaid
- ▫ SCHIP (State Children's Health Insurance Program)
- ▫ Military health care (e.g. TRICARE/VA/CHAMP-VA)
- ▫ Indian Health Service
- ▫ State-sponsored health plan
- ▫ Other government program
- ▫ Single service plan (e.g. dental, vision, prescription)
- ▫ No coverage of any type **[GO TO STAYJOB]**
- ▫ Don't know **[GO TO STAYJOB]**

INSREF_APPT Was there ever a time when health insurance refused to cover a medical appointment for your cancer with the doctor or the facility of your choice?

- ▫ Yes
- ▫ No
- ▫ Doesn't applyDon't know
- ▫ Does not apply

INSREF_OPIN Was there ever a time when health insurance refused to cover a second opinion about your cancer?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

INSREF_TEST Was there ever a time when health insurance refused to cover a test or procedure recommended by your doctors for your cancer care and treatment?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

INSREF_MED Was there ever a time when health insurance refused to cover a medication prescribed for your cancer care?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

STAYJOB During your cancer diagnosis and treatment, did you ever stay at a job in part because you were concerned about losing your health insurance?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

LOSE_CANC Were you ever concerned about losing your health insurance because of your cancer?

- ☐ Yes
- ☐ No
- ☐ Does not apply

UNINSURED At any point during your cancer diagnosis or treatment, were you uninsured or did you lose your health insurance coverage?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Does not apply

DENY_INS Were you ever denied health insurance coverage because of your cancer?

- ☐ Yes
- ☐ No
- ☐ Don't know

- ☐ Does not apply

SECTION I: EMPLOYMENT

INTRO9 **t**he following questions are about your occupational status and experiences with work before, during, and after your cancer treatment.

EMPLOY At the time of your ovarian cancer diagnosis, what was your employment status?

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Self-employed
- ☐ Unemployed and looking for work **[GO TO SECTION J]**
- ☐ Unemployed and not looking for work **[GO TO SECTION J]**
- ☐ Homemaker **[GO TO SECTION J]**
- ☐ Retired **[GO TO SECTION J]**
- ☐ On disability **[GO TO SECTION J]**
- ☐ Other **[GO TO SECTION J]**

EMP_TYPE What kind of work were you doing at the time of you cancer diagnosis? *For example: teacher, nurse, lawyer, etc.*

LEAVE_YN Did you take any leave or time off from work for any of your cancer treatment and/or recovery?

- ☐ Yes
- ☐ No **[GO TO WORKAFTER_YN]**

LEAVE_TYPE What kind of leave or time off did you take during your treatment and/or recovery? *Please select all that apply.*

- ☐ Paid sick leave
- ☐ Unpaid sick leave
- ☐ Other paid time off
- ☐ Family Medical Leave Act (FMLA)
- ☐ Disability leave
- ☐ There was no time off
- ☐ Quit job
- ☐ Other, *please specify:* _____

WORKAFTER_YN After your treatment and recovery, did you continue working for pay?

- ☐ Yes
- ☐ No **[GO TO TRTMNT_AFTER]**

WORKTX_AFTER After your treatment and recovery, did you…. *Please select all that apply.*

- ☐ Continue at the same job you had before your cancer diagnosis
- ☐ Have a different job than the one you had before your cancer diagnosis
- ☐ Go part-time or worked fewer hours at the same job
- ☐ Have different duties or responsibilities at the same job
- ☐ Decided not to pursue a promotion

PROGRAMMER: IF WORKTX_AFTER NOT MISSING, GO TO DISCRIM.

TRTMNT_AFTER After your treatment and recovery, did you….

- ☐ Retire
- ☐ Go on disability
- ☐ Quit working
- ☐ Lose your job or get fired
- ☐ Continue looking for work
- ☐ Other

DISCRIM Did you ever feel like you were experiencing discrimination in your workplace resulting from your cancer diagnosis, treatment, and its lasting effects?

- ☐ Yes
- ☐ No

SECTION J: FINANCIAL IMPACT

INTRO10 Next, we will ask about the possible financial impact cancer has had on your life.

FINANCES To what degree has cancer caused financial problems for you and your family?

- ☐ A lot
- ☐ Some
- ☐ A little
- ☐ None at all

BORROW Have you or has anyone in your family had to borrow money or go into debt because of your cancer or its treatment?

- ☐ Yes
- ☐ No

BANKRUPT Did you or your family ever file for bankruptcy because of your cancer or its treatment?

- ☐ Yes
- ☐ No

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SACRIFICE Have you or your family ever had to make other kinds of financial sacrifices because of your cancer or its treatment?

- ☐ Yes
  - *Please describe what kind of financial sacrifices:* _____
- ☐ No

MEDBILLS Have you ever worried about having to pay large medical bills related to your cancer?

- ☐ Yes
- ☐ No

UNABLE Keeping in mind medical visits for your cancer, its treatment, or the lasting effects of that treatment, have you ever been unable to cover your share of the costs of those visits?

- ☐ Yes
- ☐ No

OUTOFPOCKET Overall, how much do you think you or your family spent out-of-pocket on co-pays, medical bills, and other expenses related to your cancer, its treatment, and/or the lasting effects of that treatment?

- ☐ Less than $2,000
- ☐ Between $2,000 and $5,000
- ☐ Between $5,001 and $10,000
- ☐ Between $10,001 and $25,000
- ☐ More than $25,000

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SECTION K: OTHER MEDICAL CONDITIONS

INTRO11 We are also interested in learning about other medical conditions, aside from cancer, that you may have and any medications, either prescription or over-the-counter, you may be taking to address health issues.

OTHMED_x, DIAG_x Have you ever been diagnosed with any of the following medical conditions? *Please select all the apply.*

				If Yes, Were you diagnosed with this condition before or after you received treatment for ovarian cancer?	Diagnosis before or after ovarian cancer treatment	
	Yes	No	Don't Know		Before	After
a. Hypertenion (High blood pressure)	☐	☐	☐		☐	☐
b. High cholesterol	☐	☐	☐		☐	☐
c. Heart problems (such as heart attack, coronary artery disease, cogestive heart failure, irregular heartbeat, etc.)	☐	☐	☐		☐	☐
d. Stroke, including mini-strokes or blood clots in the brain	☐	☐	☐		☐	☐
e. Diabetes, high blood sugar, or sugar in the urine	☐	☐	☐		☐	☐
f. Arthritis	☐	☐	☐		☐	☐
g. Osteoprosis or Osteopenia (loss of bone mass, fragile or soft bones)	☐	☐	☐		☐	☐
h. Asthma	☐	☐	☐		☐	☐
i. Emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)	☐	☐	☐		☐	☐
j. Kidney disease	☐	☐	☐		☐	☐
k. Stomach and/or intestinal problems, such as Crohn's disease, ulcers, or inflammatory bowel disease	☐	☐	☐		☐	☐
l. Anemia	☐	☐	☐		☐	☐
m. Other, *please specify:*	☐	☐	☐		☐	☐

DEPRESS Have you ever taken any prescription medication for depression? *Examples include Zoloft, Prozac, Sarafem, Lexapro, Celexa, Paxil, Effexor, Cymbalta, or Wellbutrin.*

- ☐ Yes

- ◻ No **[GO TO ANXIETY]**
- ◻ Don't know **[GO TO ANXIETY]**

DEPRESS_BDA Did you take this medication before, during, or after your cancer diagnosis and treatment? *Please select all that apply*.

- ◻ Took medication BEFORE cancer diagnosis and treatment
- ◻ Took medication DURING cancer diagnosis and treatment
- ◻ Took medication AFTER cancer diagnosis and treatment

DEPRESS_CURR Are you currently taking medication for depression?

- ◻ Yes
- ◻ No
- ◻ Don't know

DEPRESS_RX Who wrote the prescription for your anti-depressant medication?

- ◻ Primary care doctor
- ◻ Oncologist
- ◻ Psychiatrist
- ◻ Other, *please specify:* _____

ANXIETY Have you ever taken prescription medication for anxiety or for feeling worried, anxious, or nervous? *Examples include Xanax*, *Niravam*, *Klonopin*, *Ativan*, *Valium*, *Vanspar*, *or a beta-blocker like Bevibloc or propranolol*.

- ◻ Yes
- ◻ No **[GO TO PAIN_OTC]**
- ◻ Don't know **[GO TO PAIN_OTC]**

ANXIETY_BDA Did you take this medication before, during, or after your cancer diagnosis and treatment? *Please select all that apply*.

- ◻ Took medication BEFORE cancer diagnosis and treatment
- ◻ Took medication DURING cancer diagnosis and treatment
- ◻ Took medication AFTER cancer diagnosis and treatment

ANXIETY_CURR Are you currently taking medication for depression?

- ◻ Yes
- ◻ No
- ◻ Don't know

ANXIETY_RX Who wrote the prescription for your anti-depressant medication?

- ◻ Primary care doctor
- ◻ Oncologist
- ◻ Psychiatrist
- ◻ Other, *please specify:* _____

PAIN_OTC Are you currently taking any over-the-counter, or non-prescription, medication to help you deal with pain? *Examples include Advil, Tylenol, or Motrin.*

- ☐ Yes
- ☐ No

PAINMED Are you currently taking any ***prescription*** medications to help you deal with pain? *Examples include Hydrocodone, Percocet, or Vicodin.*

- ☐ Yes
- ☐ No **[GO TO CHOLEST]**

PAINMED_WHY Is the pain for which you take these medications for due to your cancer, its treatment, or its late and long-term side effects?

- ☐ Yes
- ☐ No

PAINMED_BDA Did you start taking prescription pain medication before, during, or after your ovarian cancer diagnosis and treatment? *Please select all that apply.*

- ☐ Took medication BEFORE ovarian cancer diagnosis and treatment
- ☐ Took medication DURING ovarian cancer diagnosis and treatment
- ☐ Took medication AFTER ovarian cancer diagnosis and treatment

CHOLEST Have you <u>ever taken</u> prescription medication to lower your cholesterol? These medications are usually called statins. *Examples include Zocor, Lipitor, Crestor, or Pravachol/Prevastin.*

- ☐ Yes
- ☐ No **[GO TO BP_EVER]**
- ☐ Don't know **[GO TO BP_EVER]**

CHOLEST_BDA Did you take this medication before, during, or after your cancer diagnosis and treatment? *Please select all that apply.*

- ☐ Took medication BEFORE cancer diagnosis and treatment
- ☐ Took medication DURING cancer diagnosis and treatment
- ☐ Took medication AFTER cancer diagnosis and treatment

CHOLES_CURR Are you <u>currently</u> taking medications to help lower your cholesterol?

- ☐ Yes
- ☐ No
- ☐ Don't know

BP_EVER Have you ever taken prescription medication to help lower your blood pressure? *Examples include Lisinopril or Prinivil, Amoldipine or Norvasc, Metoprolol or Toprol, and Losartan or Cozaar.*

- ☐ Yes
- ☐ No **[GO TO INSULIN]**
- ☐ Don't know **[GO TO INSULIN]**

BP_BDA Did you take this medication before, during, or after your cancer diagnosis and treatment? *Please select all that apply.*

- ☐ Took medication BEFORE cancer diagnosis and treatment
- ☐ Took medication DURING cancer diagnosis and treatment
- ☐ Took medication AFTER cancer diagnosis and treatment

BP_CURR Are you currently taking medication to help lower your blood pressure?

- ☐ Yes
- ☐ No
- ☐ Don't know

INSULIN Have you ever taken insulin by injection or an oral prescription medication for diabetes? *Examples of oral medications include Metformin or Glucophage, Actos, Januvia, or Invokana.*

- ☐ Yes
- ☐ No **[GO TO SLEEP]**
- ☐ Don't know **[GO TO SLEEP]**

INSULIN_BDA Did you take this medication before, during, or after your cancer diagnosis and treatment? *Please select all that apply.*

- ☐ Took medication BEFORE cancer diagnosis and treatment
- ☐ Took medication DURING cancer diagnosis and treatment
- ☐ Took medication AFTER cancer diagnosis and treatment

INSULIN_CURR Are you currently taking medication for diabetes?

- ☐ Yes
- ☐ No
- ☐ Don't know

SLEEP Have you ever taken a prescription medication to help you sleep? *Examples include Silenor, Lunesta, Ambien, or Restoril*

- ☐ Yes
- ☐ No **[GO TO SECTION L]**
- ☐ Don't know **[GO TO SECTION L]**

SLEEP_BDA Did you take this medication before, during, or after your cancer diagnosis and treatment? *Please select all that apply.*

- ☐ Took medication BEFORE cancer diagnosis and treatment

- ☐ Took medication DURING cancer diagnosis and treatment
- ☐ Took medication AFTER cancer diagnosis and treatment

SLEEP_CURR Are you currently taking medication to help you sleep?

- ☐ Yes
- ☐ No
- ☐ Don't know

SECTION M: YOUR QUALITY OF LIFE

INTRO12 The following questions are about your current health and well-being.

GLOBAL_xx Please respond to each item by marking one box per row.

Variable name		**Excellent**	**Very Good**	**Good**	**Fair**	**Poor**
GLOBAL01	In general, would you say your health is:	☐	☐	☐	☐	☐
GLOBAL02	In general, would you say your quality of life is:	☐	☐	☐	☐	☐
GLOBAL03	In general, how woud you rate your physical health?	☐	☐	☐	☐	☐
GLOBAL04	In general, how would you rate your mental health, including your mood and your ability to think?	☐	☐	☐	☐	☐
GLOBAL05	In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
GLOBAL09	In general, please rate how well you carry out your usual social activities and roles. *(This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)*	☐	☐	☐	☐	☐

GLOBAL06 To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- ☐ Completely
- ☐ Mostly
- ☐ Moderately
- ☐ A little
- ☐ Not at all

GLOBAL10 In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

- ☐ Never

- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

GLOBAL08 In the past 7 days, how would you rate your fatigue on average?

- ☐ None
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Very severe

GLOBAL07 In the past 7 days, how would you rate your pain on average?

- ☐ 0 No Pain
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Worst Pain Imaginable

SLEEP_SATIS How satisfied are you with the sleep you are getting?

- ☐ Very satisfied
- ☐ Somewhat satisfied
- ☐ Neither satisfied nor dissatisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

PAST4_x In the past 4 weeks…….

	All of the time	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. About how often did you feel tired for no good reason?	☐	☐	☐	☐	☐
b. About how often did you feel nervous?	☐	☐	☐	☐	☐
c. About how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
d. About how often did you feel hopeless?	☐	☐	☐	☐	☐
e. About how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
f. About how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐

g. About how often did you feel depressed?	☐	☐	☐	☐	☐
h. About how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
i. About how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
j. About how often did you feel worthless?	☐	☐	☐	☐	☐

SECTION M: ABOUT YOU

INTRO13 The final set of questions is about you.

SCHOOL What is the highest grade or level of schooling you completed?

- ◻ Grade 11 or less
- ◻ Completed high school
- ◻ Post high school training other than college (vocational or technical)
- ◻ Some college
- ◻ College graduate
- ◻ Postgraduate

MARITAL What is your marital status?

- ◻ Married
- ◻ Living as married
- ◻ Divorced/Separated
- ◻ Widowed
- ◻ Single, never been married

ETHNICITY Are you of Hispanic, Latino/a, or Spanish origin?

- ◻ Yes
- ◻ No **[GO TO RACE]**

ETH_GROUP Which group are you from?

- ◻ Mexican, Mexican American, Chicano/a
- ◻ Puerto Rican
- ◻ Cuban
- ◻ Dominican
- ◻ Central or South American
- ◻ Other Hispanic, Latino/a, or Spanish origin

RACE What is your race? *You may select multiple categories.*

- ◻ White
- ◻ Black or African American
- ◻ Asian

- ☐ Native Hawaiian or Pacific Islander
- ☐ American Indian or Alaska Native

EMPLOY_CURR What is your current occupational status?

- ☐ Employed (full-time, part-time, or self-employed)
  - ↳ What kind of work are you currently doing? *For example: teacher, postal worker, nurse, etc.* _____
- ☐ Unemployed
- ☐ Homemaker
- ☐ Student
- ☐ Retired
- ☐ Disabled
- ☐ Other, *please specify:* _____

HI_TYPE What kind of health insurance do you have? Please select all that apply.

- ☐ Health insurance through your (or your spouse's) employer
- ☐ Private health insurance, individually purchased
- ☐ Medicare
- ☐ Medi-Gap
- ☐ Medicaid
- ☐ SCHIP
- ☐ Military health care (TRICARE/VA/CHAMP-VA)
- ☐ Indian Health Service
- ☐ State-sponsored health plan
- ☐ Other government program
- ☐ Single service plan (e.g. dental, vision, prescription)
- ☐ No coverage of any type **[GO TO CHILDREN]**
- ☐ Don't know **[GO TO CHILDREN]**

NOHI_12MOS In the past 12 months, was there any time when you did not have any health insurance coverage?

- ☐ Yes

- ☐ No
- ☐ Don't know

CHILDREN Do you have any children?

- ☐ Yes
- ☐ No **[GO TO INCOME]**

CHILD_NUM How many children to you have?

_____ Number of children

UNDER18 How many are under age 18?

_____ Number of children under 18

INCOME Thinking about all the members of your family living in your household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

- ☐ Less than $20,000
- ☐ $21,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $199,999
- ☐ $200,000 or more
- ☐ Don't know

STATE What state do you live in?

_____

ZIP_CODE What zip code to you live in?

_ _ _ _ _

[INCENT2] Congratulations, you are eligible for a $10 Amazon gift code. Below is your gift code number:

[GIFTCODE DISPLAYED HERE]

Would you like us to email or mail the above giftcode number to you?

- € Email only → GO TO WEBINEM1 & WEBINEM2
- € Mail only → GO TO INC_ADDRESS
- € I do not want the giftcode sent to me → GO TO SOCIAL NETWORK QUESTIONS

[WEBINEM1] Please enter your email address: _____

[WEBINEM2] Please reenter your email address:

[INC_ADDRESS] Is this your correct mailing address?

Street:
Apartment:
City:
State:
Zip Code:

Social Network Questions

[SECTION NOTE: Seventeen (17) respondents from both the registry sample and the social-media sample will be selected randomly as seeds. In respondent-driven sampling (RDS), a seed is an individual who uses her network to recruit other participants into the study. The seventeen seeds will complete an additional section of the survey, including social network questions as listed below.]

NETWORK1 Are there any other women you know that have been diagnosed with cancer of the ovary, fallopian tube, or peritoneum who may be interested in participating in this study?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

NETWORK2 Are these women who are:

- at least 18 years of age,
- have been diagnosed with ovarian, fallopian tube, or primary peritoneal cancer,
- and have undergone some form of treatment?
  - ☐ Yes

- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

NETWORK3 On the next screen, we will ask for the names and contact information for up to three other women that you know who may be interested in participation.

- ☐ CONTINUE

NETWORK4 Please enter the name and contact information for the women that you know. Women will be selected at random for participation. You will receive an additional $10 for each women you refer who also participates.

Woman 1

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Email address: _____

Woman 2

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Email address: _____

Woman 3

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

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Email address: _____

THANKYOU Thank you for your time and your effort completing this survey. We appreciate your assistance with this important study.