

Participant_ ID:

Saliva Collection Form
 (To be filled out by the participant on the day of saliva collection)

IMPORTANT: Please read the saliva collection instructions before you complete this form.

Please answer the question below after completing saliva collection for each time point.

Date of Saliva Sample Collection: _____	
Is today a weekday or a weekend day?	<input type="checkbox"/> Weekday <input type="checkbox"/> Weekend
Did you wake up on your own this morning?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Time	
At what time did you go to bed last evening?	a.m. / p.m.
At what time do you usually go to bed?	a.m. / p.m.
At what time did you collect saliva #1 (Awakening)?	a.m. / p.m.
At what time did you collect saliva #2 (+30 Minutes)?	a.m. / p.m.
At what time did you collect saliva #3 (+45 Minutes)?	a.m. / p.m.
At what time did you collect saliva #4 (+60 Minutes)?	a.m. / p.m.

Please indicate if you have any oral health problems/injuries: Yes No

Please indicate how you would rate your sleep last night with an X in one of the sections on the line:

I	I	I	I	I	I	I
Best						Worst
Possible						Possible
Sleep						Sleep

Public reporting burden of 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 CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA 0920-XXXX

Saliva Collection Form: For Office Use only
(For use on the day of clinic appointment)

Participant_ ID:

Date of Saliva Collection: _____

**Attention of clinic personnel: Please check the color of all four saliva collections
In the box below at time you receive saliva samples on the day of clinic appointment.**

Office Use Only:

Color of saliva #1:

- 1 Clear
- 2 Brown
- 3 Red
- 4 Pink
- 6 Other

(Specify: _____)

Color of saliva #2:

- 1 Clear
- 2 Brown
- 3 Red
- 4 Pink
- 6 Other

(Specify: _____)

Color of saliva #3:

- 1 Clear
- 2 Brown
- 3 Red
- 4 Pink
- 6 Other

(Specify: _____)

Color of saliva #4:

- 1 Clear
- 2 Brown
- 3 Red
- 4 Pink
- 6 Other

(Specify: _____)