Form Approved
OMB Control No.: 0920-XXXX
Expiration date: 09/30/2023

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?	❑ Weekday	❑ Weekend
Did you wake up on your own this morning?	❑ Yes	❑ 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:

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Best Possible Sleep — Worst Possible Sleep

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:	Color of saliva #2:	Color of saliva #3:	Color of saliva #4:
☐ 1 Clear	☐ 1 Clear	☐ 1 Clear	☐ 1 Clear
☐ 2 Brown	☐ 2 Brown	☐ 2 Brown	☐ 2 Brown
☐ 3 Red	☐ 3 Red	☐ 3 Red	☐ 3 Red
☐ 4 Pink	☐ 4 Pink	☐ 4 Pink	☐ 4 Pink
☐ 6 Other	☐ 6 Other	☐ 6 Other	☐ 6 Other
(Specify: _____)	(Specify: _____)	(Specify: _____)	(Specify: _____)