

INVITATION CALL SCRIPT: PREVIOUS ASD DIAGNOSIS

NOTE: RESPONSE FROM SUBJECT (GOTO INTRO I)
 SUBJECT DID NOT RESPOND(GOTO INTRO II)

INTRODUCTION I - RESPONSE RECEIVED

Hello, May I speak with **[SUBJECT NAME/BIOMOM]**.

a. If not SUBJECT: How can I reach her? / What time is best to call back?

 (UPDATE CONTACT INFO/END CALL)

My name is [NAME] and I’m calling regarding the national research study called the Study to Explore Early Development or SEED. The study is sponsored by the US Centers for Disease Control and Prevention. I received your [RESPONSE MODE] and would like to provide additional information regarding the study. **(GO TO 2 BELOW)**

INTRODUCTION II - NO RESPONSE RECEIVED

Hello, May I speak with **[SUBJECT NAME/BIOMOM]**.

a. If not SUBJECT: How can I reach her? / What time is best to call back?

 (UPDATE CONTACT INFO/END CALL)

My name is [NAME] and I’m calling to follow-up on an invitation sent to you from [SITE] about a national research study called the Study to Explore Early Development or SEED. The study is sponsored by the US Centers for Disease Control and Prevention.

- 1. Did you receive the invitation? YES..... (CONTINUE)
 NO..... (VERIFY ADDRESS/CONTINUE)

- 2. Is this a good time to talk to you about the study? (Scner~5 min/Enroll ~25min)
 YES..... (GO TO RECORD CALL) below
 NO..... (go to 3.)
 REFUSED..... (GO TO REFUSAL) p.7

- 3. When is a better time to call back?

DAY _____ DATE _____ TIME(S) _____ AM/PM

Public reporting burden of this collection of information is estimated to average 20 minutes, 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).

RECORD CALL

If it's okay with you, I'd like to record this call for training purposes. (TURN ON RECORDER)

4. The recorder is on will it be OK to record this call?YES

NO (TURN OFF RECORDER/CONT)

INVITATION

SEED is one of the largest studies about child development and the causes of developmental disabilities and autism spectrum disorders. To make the study a success, we hope to enroll mothers and their children with and without developmental disabilities. We would like for everyone who is invited to participate in this study. But the first step in the process is to see if you are eligible. Thank you!

ELIGIBILITY SCREENING:

E1. Are you the biological mother of a child born January 1, 2014 – December 31, 2017? **Y** **N** (IF NO, GO TO a. / CONFIRM BELOW)

a. If not SUBJECT: How can I reach her? / What time is best to call back?

_____ (UPDATE CONTACT INFO/END CALL)

b. If no child born in that date range, thank person, END CALL.

c. If more than one child born in that date range, specify child's name, go to E2b.

E2a. What is your child's full name _____

E2b. What is <CHILD> date of birth? _____ / _____ / _____ (VERIFY/IF INELIG GO TO INELIGIBLE BLOCK A)

E3. Does <CHILD> live with you? **Y** **N** (IF NO/ GO TO INELIGILBE BLOCK B)

E4. Do you have legal guardianship of <CHILD> **Y** **N** (IF NO/ GO TO INELIGILBE BLOCK E)

E5. Have you cared for <CHILD> since birth (or since 6 months old)? **Y** **N** (IF NO/ GO TO INELIGILBE BLOCK F)

E6. What county were you living in when <CHILD> was born? _____ (IF OUT OF AREA/ GO TO INELIGILBE BLOCK D)

E7. What county do you currently live in? _____ (IF OUT OF AREA/ GO TO INELIGILBE BLOCK C)

E8. Is English [OR SPANISH – select sites] the main language spoken in your home? **Y** **N** (IF NO ASK a.) below)

a. Do you and <CHILD> understand and speak English/Spanish? **Y** **N** (IF NO/ GO TO INELIGILBE BLOCK H)

E9. Does <CHILD> have problems seeing/hearing/or moving around by him/herself? **N** **Y** (ASK a, b, c)

a. Please describe condition _____

b. Has the problem been corrected? **N** **Y** (GO TO E10 BELOW)

c. A trained professional will assess your child's development thru games that require seeing,

hearing, and moving around. Do you think your child will be able to participate in the developmental evaluation? Y (GO TO NOTE BELOW) N

(IF NO TO b or c/ GO TO INELIGILBE BLOCK G)

NOTE: OUR STUDY CLINICIAN MAY CALL TO INQUIRE ABOUT <CHILD> CONDITION AS IT RELATES TO THE DEVELOPMENTAL EVALUATION. When is the best time to call?

E10. Has <CHILD> been dx with Autism or an Autism Spectrum Disorder (ASD)? Y N

E11. Have any of your other children ever participated in SEED? N Y (Ask a, b, c, d)

- a. How many? (If more than one other child, for each child ask questions b, c and d)
- b. What is your child's full name?
- c. What is your child's date of birth?
- d. What is your child's sex? (or, based on name, confirm if it is a boy or girl)

(IF OTHER CHILDREN IN SEED, SUBJECT IS INELIGIBLE/ GO TO INELIGILBE BLOCK I)

Thank you! You are eligible to participate. (VERIFYCONTACT INFO BEFORE ENDING CALL- SEE BIOLOGICAL MOTHER CONTACT INFO BLOCK)

BACKGROUND AND STUDY STEPS OVERVIEW

Next, I'd like to tell you a bit more about the study including what you would be asked to do if you decide to participate. If you decide to enroll, you will receive an additional incentive for your participation in the rest of this call. (~ 25 mins)

SEED is a national research study being conducted at 6 sites throughout the US in <participating sites>. As I said, SEED is one of the largest studies about child development and the causes of developmental disabilities and autism spectrum disorders.

The study consists of several different parts including a telephone interview, completing questionnaires, a developmental assessment with the child, and a brief physical exam.

Your participation in each component is voluntary and consented separately.

We estimate that your total involvement will take approximately **9 hours** over the course of several months and you can receive an incentive up to **\$300** depending on the number of components you complete. The incentive is to thank you for your time and to cover any out of pocket expenses.

If you decide to participate, the Enrollment Packet will be mailed within one week.

Enrollment Packet - The EP contains...

-Written materials that will further explain the study (Informed Consent/ Bill of Rights)

Maternal Interview (1 hour - \$30)

Next will be a telephone interview about your health before & during pregnancy & <CHILD's> development after birth

One packet of forms – (about 2 hours - \$40) After the maternal interview we will send you a packet of forms for you to complete about your child's development and your family's health. These can be done at home alone or with help from study staff at the clinic visit or over the phone. This packet will also have information that will help you prepare for the clinic visit.

Clinic/Home Visit - (Approx 5.5 hours for ASD -\$200). We will also arrange for an evaluation of your child's development either at a clinic or in your home. At this visit, we will obtain your written consent, review study documents, administer the Developmental Evaluation and have a brief physical examination. The clinic visit can be conducted at <site specific locations> and we require you to sit in during the visit.

- a. **Developmental Evaluation of** <CHILD>(cognitive & emotional dev., lang, adaptive & motor skills)
-A trained professional will assess<CHILD's> development through games & provide a feedback letter with results & recommendations if necessary, approx. 4 weeks after the visit.

Also, during clinic visit, a trained professional will ask you additional questions about<CHILD's> development and behavior and any services <CHILD> receiving.

(ADIR, VINELAND, AND SERVICES AND TREATMENTS QUESTIONNAIRES)

- b. **Brief Physical Exam** during the brief physical exam we will
- Collect saliva from you and <CHILD>, and from <CHILD's> biological father, if he is available
 - Measure height and head circumference of you and <CHILD> and weigh <CHILD>
 - Draw blood from you & <CHILD>

Do you have any questions about the study?

NO

YES

VERBAL CONSENT TO ENROLL

The next step in this call is for me to read to you the Verbal Consent regarding enrollment in the study. Afterwards, you may tell me your decision.

Your participation is voluntary. You can choose to stop at any time. There is little risk in taking part in this study; however, you may feel uncomfortable answering sensitive questions about <CHILD> development. You can also skip any questions you feel uncomfortable answering.

Answering these questions will not benefit your family directly. Findings may help us learn more about what causes autism and other developmental problems. This may lead to better services and treatments for children with developmental disabilities.

We understand that you may have concerns about your privacy. In order to protect the privacy of all participants, <site> applied for and received a Certificate of Confidentiality. The Certificate of Confidentiality guarantees that any information that is collected that could identify you or <CHILD> will be used only for this project. It cannot be given to anyone else unless you give your written consent or otherwise required by law.

All of the responses from these questions will be kept private. The information you give will only be used for this study. Your information will remain confidential unless otherwise required by law. We will never use your name or <CHILD's> name in any report. The information you give will always be combined with information from all other participants.

You will be given a study ID. The study ID will be recorded on all study forms. Your name or other identifying information will not be on the study forms. Only the necessary study staff will have access to your personal information.

If you have any concerns about the study or how it is conducted or if you feel you have been harmed by participating in the study, you may contact <Project Coordinator> at <number>. "If you have any questions about your rights as a participant in this study, please contact <site specific at phone number>. Leave a message with your name, phone number, and refer to <site specific protocol number>, and someone will call you back."

Again, I want to remind you that your participation in this research study is voluntary; you can choose to stop at any time

Do you have any questions about the consent form? NO YES

Do you verbally consent to me enrolling you in the study?

NO: Thank you for your time. If you change your mind please call <site main number>. **END CALL, after getting contact information to mail incentive)**

YES: Next, I'd like to ask you questions about <CHILD's> development. Before I ask these questions, I would like to get your verbal consent. To ask these questions. The Verbal Consent Form that I just read to you is also used to obtain your verbal consent for these questions.

Do you verbally consent to me asking you questions about <CHILD> development?

NO: Thank you for your time. If you change your mind please call <site main number>. **END CALL, after getting contact information to mail incentive)**

YES: Thank you. Please answer "YES" or "NO" if any of the following behaviors were present during the past 3 months. There are no right or wrong answers; our goal is to get a general idea of how <CHILD> responds in certain situations.

ADMINISTER SCQ

SCQ Score: _____ (Index child)

_____ASD 9.0 hours - \$300

Thank you! Now I would like to ask you just a few questions about yourself, <child's> father and <child>.

Is <CHILD> Male _____ Female _____ (This may have already been ascertained)

What is your date of birth? _____/_____/_____

Next, I'd like to get some information on where to mail study materials and the best way to reach you for future calls. (complete BIOLOGICAL MOTHER CONTACT INFO BLOCK)

Does <CHILD'> biological father live with you and <CHILD>? Y N

IF NO: Are you able to provide the father's name and contact info? Y N

(If YES, complete BIOLOGICAL FATHER CONTACT INFO BLOCK)

We would also like the name of another person we can contact in case we need to reach someone for you during our visit with you and your child. (complete EMERGENCY CONTACT INFO BLOCK)

Twice a year we email participants a SEED newsletter informing them of the progress we're making in the study.

Are you interested in receiving the newsletter? Y N

IF YES/ What is your email address? (Record below)

IF NO (GO TO UPCOMING APPTS. below)

Email: _____

UPCOMING APPOINTMENTS

The final step in the process today is to schedule your two telephone interviews.

Follow-Up 1 Call

The first telephone interview is to obtain specific dates relating to your pregnancy with <CHILD>. This call will take approximately 15 minutes. When is the best time to call?

DAY _____ DATE _____ TIME(S) _____ AM/PM

Maternal Interview

The second interview will take approximately 60 minutes. We will ask you questions about your health before and during your pregnancy and <CHILD> development after birth. This 2nd appointment will need to be scheduled at least 2 weeks after the first call. When is the best time to call?

DAY _____ DATE _____ TIME(S) _____ AM/PM

Thank you for your time and willingness to take part in the SEED study.

(END CALL)

INELIGIBLE – if ineligible, read only the option below that pertains to this family

Unfortunately, you are not eligible to participate. One of the requirements of the study is that....

- A. The <CHILD> must be born between 1/1/2014 - 12/31/2017
- B. The <CHILD> must currently live with biological mother to participate
- C. The <CHILD> must currently live in a participating county
- D. The biological mom must have lived in one of the participating counties when <CHILD> was born
- E. Biological mother must have Legal Guardianship of <CHILD>
- F. Biological mother must have cared for child since birth or (since 6 months old).
- G. Child must not be deaf or blind and must not have mobility restrictions that would greatly restrict participation in the developmental evaluation.
- H. The bio mom must be able to “competently” communicate orally in English [or SPANISH – select sites]
- I. Child must not have a sibling taking part in the study.

Thank you for your time today. (VERIFY CONTACT INFO BEFORE ENDING CALL – GO TO BIOLOGICAL MOTHER CONTACT INFO BLOCK)

REFUSAL

Is there any particular reason you decided not to participate?

I respect your decision! Do you mind answering a few screening questions, before hanging up?

REFUSAL/ELIGIBILITY SCREENING

- R1. Are you the bio mother of <CHILD> born between 1/1/2008 - 12/31/2011? **Y N**
- R2. Do you have legal guardianship of <CHILD>? **Y N**
- R3. Have you cared for <CHILD> since birth/6 months of age? **Y N**
- R4. Does <CHILD> live with you? **Y N**
- R5. Is <CHILD> Male _____ Female _____
- R6. What county were you living in when <CHILD> was born?

- R7. Is <CHILD> deaf or blind? **Y N**
- R8. Do you/<CHILD> currently live in <site specific counties>? **Y N**
- R9. Is English [or SPANISH select sites] the main language spoken in the home? **Y N**

R10. Does <CHILD> have an Autism Spectrum Disorder diagnosis?	Y	N
R.11 Have any of your children ever participated in SEED?	Y	N

**IF MOTHER ANSWERED ELIGIBILITY QUESTIONS,
VERIFY CONTACT INFO BEFORE ENDING CALL—GO TO BIOLOGICAL MOTHER CONTACT INFO BLOCK)**

Thank you for your time. If you change your mind please call <site main number>

(END CALL)

CONTACT INFORMATION

BIOLOGICAL MOTHER

Contact info in CIS

NAME _____

ADDRESS _____

PHONE NUMBER _____ Alt: _____

DAY _____ DATE _____ TIME(S) _____ AM/PM

BIOLOGICAL FATHER

Contact info in CIS

NAME _____

ADDRESS _____

PHONE NUMBER _____ Alt: _____

DAY _____ DATE _____ TIME(S) _____ AM/PM

EMERGENCY/ALTERNATE CONTACT

NAME _____

ADDRESS _____

PHONE NUMBER _____ Alt: _____

DAY _____ DATE _____ TIME(S) _____ AM/PM

RELATIONSHIP TO <CHILD> _____