0b. Staff ID: ☐☐☐
(To be completed by research staff member)

FOLLOW-UP FORM (Mail Version)

PPT NAME: _____ FORM CODE: S A F DATE: 10/08/2024 Version 4.0
(To be completed by research staff member)

ADMINISTRATIVE INFORMATION

Instructions: *Please tell us who is completing this form and today's date.*

Date of last contact with research team: ☐☐/☐☐/☐☐☐☐
(To be completed by research staff member) Month Day Year

Full name of person completing this form: _____
(first) (last)

Are you the study participant?

Yes.....☐→ *Skip to Question 0a.*
No .....☐→ *Continue to next question.*

Are you a proxy for the study participant?

Yes.....☐
No .....☐

0a. Today's Date: ☐☐/☐☐/☐☐☐☐
Month Day Year

QUESTIONS

Instructions: *Please answer the questions below to the best of your ability. Please answer the questions in the order they appear on the form and follow directions to skip questions, as applicable. Please note that some question numbers are not in order and some numbers are skipped.*

CANCER INFORMATION

2a. Since we last contacted you, has a doctor said you had cancer?

Yes.....☐→ *Continue to Question 2a1.*
No .....☐→ *Skip to Question 19.*

2a1. In what part of the body was the most recently diagnosed cancer located?

_____

2b. What is the approximate date the cancer was diagnosed? ☐☐/☐☐☐☐
Month Year

HOSPITAL ADMISSIONS

19. Since our last contact, were you hospitalized or did you stay in a hospital observation unit for any reason?

Yes..... ☐ → *Continue to Question 20a to list hospitalizations.*
No ..... ☐ → *Skip to Question 25.*

HOSPITALIZATION FOR ANY REASON

20a. Hospitalization Reason: _____

20b. Hospital Name, City, State: _____

20c. Approximate date of hospitalization ☐☐/☐☐☐☐
Month Year

HOSPITALIZATION FOR ANY REASON

21a. Hospitalization Reason: _____

21b. Hospital Name, City, State: _____

21c. Approximate date of hospitalization ☐☐/☐☐☐☐
Month Year

HOSPITALIZATION FOR ANY REASON

22a. Hospitalization Reason: _____

22b. Hospital Name, City, State: _____

22c. Approximate date of hospitalization ☐☐/☐☐☐☐
Month Year

EMERGENCY ROOM OR OUTPATIENT CARE

25. Were you seen at an emergency room or a medical facility for outpatient treatment since our last contact?

Yes..... ☐ → *Continue to Question 26.*
No ..... ☐ → *Skip to Question 28.*

26. Was this related to a heart problem or difficulty breathing?

Yes..... ☐ → *Continue to Question 27a.*
No ..... ☐ → *Skip to Question 28.*

Emergency room/medical facility information

27a. ER/Facility Name, City, State: _____

27b. Approximate date ☐☐/☐☐☐☐
Month Year

LONG-TERM CARE FACILITY

28. Since our last contact, have you stayed overnight as a patient in a long-term care facility?

Yes.....☐
No .....☐

29. Are you currently a resident of a long-term care facility?

Yes.....☐
No .....☐

SURGICAL/MEDICAL PROCEDURES

The next questions are about surgeries and medical procedures you have received. We are interested in those that occurred in the hospital or as an outpatient.

30. Since our last contact, have you had any surgery on your heart or the arteries of your neck or legs, not counting surgery for varicose veins?

Yes.....☐
No .....☐

32. Since our last contact, have you had a balloon angioplasty or stent on the arteries of your heart, neck, or legs?

Yes.....☐→ *Continue to Question 32d.*
No .....☐→ *Stop! You have completed this form.*

Angioplasty or stent facility information

32d. Facility Name, City, State: _____

32f. Approximate date ☐☐/☐☐☐☐
Month Year

Thank you for completing this form!
Please make sure you complete all forms before mailing them back to the ARIC Study Team.