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
(To be completed by research staff member)   Version 4.0

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)

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 the participant, has a doctor said the participant had cancer?

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

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

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

HOSPITAL ADMISSIONS

19. Since our last contact, was the participant hospitalized or did the participant 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. Was the participant 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, has the participant stayed overnight as a patient in a long-term care facility?

Yes.....................☐
No......................☐

29. Is the participant currently a resident of a long-term care facility?

Yes.....................☐
No......................☐

SURGICAL/MEDICAL PROCEDURES

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

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

Yes.....................☐
No......................☐

32. Since our last contact, has the participant had a balloon angioplasty or stent on the arteries of their 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.