

	<p>- Affix label here-</p> <p>Clinical Center/ID: ___ - ___ - ___ - ___</p> <p>First Name _____ M.I. _____</p> <p>Last Name _____</p>
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1. Date of Contact: / / (M/D/Y)

2. Completed By: _____

3. Contact Type:

- ₁ Phone
- ₂ Mail
- ₃ Visit
- ₈ Other, _____

4. Status

- ₁ Consent Signed
- ₂ Consent presented and refused
- ₃ No response to contact attempts
- ₄ Not approached, reason: _____