OMB# 0925-0414 Exp: 4/06

	- Affix label here- Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __ First Name _____M.I._____ Last Name _____

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: _____