HEMO Study Form 25
HEMO QC ID Matching Form

1. Actual Patient Identification Number (from DCC patient assignment list) ..... __ __ __ __ __ __

2. Actual Patient Name Code ..... __ __ __ __

3. Visit Date ..... __ __/__ __/__ __ __ __

4. Visit Type ..... __

5. Week/Month Number ..... __ __ __

6. Quality Control ID (from DCC QC list) ..... __ __ 9 __ __ __

7. Quality Control Name Code ..... __ __ __ __

8. Type of specimen or record (1=Diet Record, 2=CBL Serum) ..... __

201. Date this form completed ..... __ __/__ __/__ __ __ __

202. Certification number of person completing this form ..... __ __ __ __ __

Clinical Center Use Only

Date Form Entered __ __/__ __/__ __ __ __ Verified?_____

Person Entering this Form_____