Form 00: Initiation Form and Locator Information, 07/01/02 (A)

SECTION A: ID ASSIGNMENT AND GENERAL INFORMATION

A1. Study ID#: Label

A2. Visit # Baseline .... BASE

A3. Date Form Completed: ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

A4. Study Staff Initials: ___ ___ ___

SECTION B: ELIGIBILITY CRITERIA

B1. Has the Patient given Informed Consent to participate? Yes .... 1 No................. 2 ➔DO NOT PROCEED

B2. Patient Gender: Female .... 1 Male .... 2 ➔INELIGIBLE

B3. What is the Patient's Birthdate? ____ ____ / ____ ____ / ____ ____ ____ ____ (Month / Day / Year) ➔MUST BE ≥ 21 YEARS OF AGE TODAY

B4. Is the patient currently enrolled or does she plan to enroll in any other intervention trial(s) in the next 2 years? Yes .... 1 No .... 2 ➔SKIP TO B5

B4a. Has the UITN Eligibility Committee approved her enrollment? Yes .... 1 No .... 2 ➔DO NOT PROCEED

B5. Expected Date of Surgery: ____ ____ / ____ ____ / ____ ____ ____ ____ (Month / Day / Year)

B6. Has the Patient been previously screened for the UITN study? Yes .... 1 No .... 2 ➔SKIP TO SECTION C

B4a. How many times has the patient been previously screened? _____ _____

B4b. Record the previous study ID number most recently assigned to the Patient: ____ ____ ____ - ____ ____ ____ ____ - ____

SECTION C: PATIENT IDENTIFYING INFORMATION

C1a-c. Patient's Name: ______________ (First) ______ (Middle initial) ______________ (Last)

C1d. Preferred Title? Mr. Mrs. Miss Ms.
Dr. Rev. Other ➔ Specify: ______________

C1e. Preferred Name? ______________________________

C2. Address: ______________________________ (Street Number / Apartment Number / Rural Route Number)
______________________________ (Street Name / St./Rd./Dr.)

C3. City: ______________ C4. State _____ _____ C5. Zip: ___ ___ ___ ___ ___

C6. 1st phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ 6a. Where? Home....... 1 Work .... 2 6b. Best time? ______ 6c. AM....... 1 PM 2

C7. 2nd phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ 7a. Where? Home....... 1 Work .... 2 7b. Best time? ______ 7c. AM .... 1 PM 2

Affix ID Label Here

SECTION D: OTHER CONTACT IDENTIFYING INFORMATION

D1. Was a Contact Person identified? Yes ....1 No .... 2 ➔**SKIP TO SECTION E**

D2. Name: ____________________ ____________________________
First Last

D3. Relation to patient: Spouse/Partner Daughter Son Mother Friend

Other ➔ Specify: ____________________

D4. 1st phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ 4a. Where? Home..... 1 Work ..... 2 4b. Best time? ______ 4c. AM ..... 1 PM...... 2

D5. 2nd phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ 5a. Where? Home ... 1 Work.... 2 5b. Best time? ______ 5c. AM ..... 1 PM...... 2

D6. Address: ____
Street Number Apartment Number Rural Route Number

____
Street Name St./Rd./Dr.

D7. City: ______________________________ D8. State: _____ _____ D9. Zip: ___ ___ ___ ___ ___

SECTION E: MEDICAL RECORD INFORMATION

a.	b.	c.
Name of institution, clinic or program.	**Medical Record Number / Source Location**	**Form(s) / Item Number (s)**
1.		
2.		
3.		
4.		
5.		
6.		