

**American College of Radiology
Imaging Network
Confidential
Participant Contact Form**

ACRIN Study 6666 Case #
PLACE LABEL HERE

Institution _____ Institution No. _____

Participant's Name _____ Participant's I.D. No. _____

Instructions: Complete this form on paper only for all enrolled subjects. This form should be filed in a locked file cabinet by Case ID number. The information on this form will also be used to contact the participant's physician in cases of disagreement and to contact the sample of women chosen for telephone survey follow up. This information will NOT become a part of the data set submitted to data management for analysis. **A copy of this form should be sent within 2 days of randomization to QOL assessment: 6666 QOL at Rhode Island Hospital/Brown University at Fax Number 401-444-0325. For questions, call 1-401-316-7520 or 401-444-3830.**

Participant Name: _____

Participant Instructions: Please provide the following information:

Address: Street: _____ **Apt. #** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone Number: _____

Best times to call: _____

Is it okay to leave a message at home? _____

Work Phone Number: _____

Best times to call: _____

Is it okay to call you at work? _____

Is it okay to leave a message at work? _____

E-Mail Address: _____

Please tell us the best way to contact you if you are chosen for the Telephone Survey: _____

Are you planning on moving in the next year? _____ **If yes, is there new contact information available now?**

Name of participant's physician: _____

Physician telephone number: _____

Physician address: _____

Telephone number of a friend or relative that we may contact if unable to reach you: _____

Name of contact: _____

Relationship to participant (family member, friend) _____