The purpose of the FH Form is to report additional participant Hospitalizations visits. This form serves as a continuation of the F2 Form. If a participant reports a visit to another Hospital (Qc Section A8 of the F2 form) use this form to document each additional Hospital visit. It is suggested that this form be administered by telephone or in-person interview. Page 1 of the FH Form serves as a coversheet and should not be given to the participant. If the FH form is completed by the RA there will be no participant signature on the form. If the FH form is completed by the participant, whether by mail or in-person, the participant should sign and date the form in the space provided.

1. **F2 Follow-up Interval**: Both date fields are required data elements, no blanks. The date fields must be completed as mm/dd/20yy.

2. **Follow-up reporting period**: Select the follow-up time point from the list provided. The FH reporting period should be the same as the F2 follow-up reporting period. Please choose only one time point. If multiple FH forms are needed for the same time point please indicate the same time point for each FH form submitted.

3. **Was the FH Form completed?** Please provide an answer to q3. If the answer to q3 is ‘no’, indicate the reason the form was not completed in q3b. If the answer to q3 is ‘yes’, indicate the method of completion in q3a.

3a. **Method(s) the FH Form was completed (check all that apply)**. Select each appropriate response from the list provided indicating all sources used to complete the FH Form.
   - **In-person interview**: Select this response if all or part of the FH Form data was collected during an in-person interview. This response signifies direct contact with the participant and expectation of FH Form submission.
   - **Telephone interview**: Select this response if all or part of the FH Form data was collected during a phone interview. This response signifies direct contact with the participant and expectation of FH Form submission.
   - **Mailing**: Select this response if all or part of the FH Form data was collected via the mail (i.e., return of completed FH).
   - **Proxy**: If a participant is incapacitated or otherwise unable to complete the FH form a proxy may completed the form.

3b. **Reason the FH Form was not completed**: (check only one)
   - **Participant Deceased**: Select this response if the participant is deceased at the time of contact. This response will trigger suppression of the FH Form.
   - **No response, multiple contact attempts made but participant has not replied**: Select this response if no contact was made, despite multiple attempts (mail, phone, or certified mail). This response will trigger suppression of the FH Form.
   - **Participant or proxy refused completion of the follow-up form**: Select this response if the participant refuses to complete the FH Form. This response will trigger suppression of the FH Form.
   - **Participant or proxy failed to return follow-up form (receipt of form confirmed)**: Select this response if the form is not returned and you have received confirmation of receipt of the form via registered mail receipt or via phone. This response will trigger suppression of the FH Form.
   - **No attempt made to administer follow-up form**: Select this response if a follow-up form is not administered to a participant. This response will trigger suppression of the FH Form.
   - **Physical Illness / cognitive impairment**: Select this response if a follow-up form is not administered to a participant due to their illness. This response will trigger suppression of the FH Form.
   - **Other, specify**: Select this response if the FH form is not completed for any other reason.
Signature of person responsible for data: Legible signature of the RA responsible for the data recorded and completed of the form.

Date of form completion: Date the FH form was completed by the responsible RA.

Person entering data onto web: Legible signature of staff entering the data, signed upon completion of this task.

Hospital# _____ The Hospital Number should be inserted here. This number will indicate the next Hospital visited by the participant.

On the F2 Form you reported you were seen at another Hospital during this interval. Please provide the Name, Address, Phone and Fax Numbers of the hospital. Medical Records may be obtained from the hospital at some future time.

a. Did you receive any of the following at this hospital? These questions are to ascertain whether the participant has received a diagnosis of Lung Cancer or other cancer or if they have had any Lung or Chest treatments of any kind. Respond with Yes, No, or I’m not sure for each answer.
   - Diagnosis of Lung Cancer
   - Treatment for Lung Cancer
   - Care related to a lung or chest condition
   - Care for complications from a lung or chest procedure
   - Diagnosis of any other cancer. If yes, please specify the type of cancer below.

b. Did you have any of the following procedures at this hospital? These questions are to ascertain whether the participant has had any procedures relating to Lung, Chest or Cancer diagnoses. A list of the most frequent tests done for Lung Cancer/Chest Disease work up is listed. Please indicate yes or no for each test or therapy listed.
   - Chest X-Ray
   - Chest CT scan (i.e., CAT scan, cardiac or heart CT, or lung CT)
   - Chest MRI (magnetic resonance imaging of chest or heart)
   - FDG-PET scan of the body
   - Nuclear Medicine scan of chest, lungs, or heart
   - Surgery to chest or lungs
   - Biopsy of chest or lung
   - Bronchoscopy (tube inserted in airways to study lungs)
   - Lung cancer chemotherapy
   - Lung cancer radiation therapy
   - Other lung test or lung cancer therapy, specify other test below

Hospital# _____ The next hospital number should be inserted here. This number will indicate the next hospital visited by the participant.

On the F2 Form you reported you were seen at another hospital during this interval. Please provide the Name, Address, Phone and Fax Numbers of the treating facility. Medical Records may be obtained from the treating facilities at some future time.

a. Did you receive any of the following at this hospital? These questions are to ascertain whether the participant has received a diagnosis of Lung Cancer or other cancer or if they have had any Lung or Chest treatments of any kind. Respond with Yes, No, or I’m not sure for each answer.
   - Diagnosis of Lung Cancer
   - Treatment for Lung Cancer
   - Care related to a lung or chest condition
   - Care for complications from a lung or chest procedure
   - Diagnosis of any other cancer. If yes, please specify the type of cancer below.
b. Did you have any of the following procedures at this hospital? These questions are to ascertain whether the participant has had any procedures relating to Lung, Chest or Cancer diagnoses. A list of the most frequent tests done for Lung Cancer/Chest Disease work up is listed. Please indicate yes or no for each test or therapy listed.

Chest X-Ray
Chest CT scan (i.e., CAT scan, cardiac or heart CT, or lung CT)
Chest MRI (magnetic resonance imaging of chest or heart)
FDG-PET scan of the body
Nuclear Medicine scan of chest, lungs, or heart
Surgery to chest or lungs
Biopsy of chest or lung
Bronchoscopy (tube inserted in airways to study lungs)
Lung cancer chemotherapy
Lung cancer radiation therapy
Other lung test or lung cancer therapy, specify other test below

Hospital#_____ The next hospital Number should be inserted here. This number will indicate the next hospital visited by the participant.

On the F2 Form you reported you were seen at another hospital during this interval. Please provide the Name, Address, Phone and Fax Numbers of the hospital. Medical Records may be obtained from this hospital at some future time.

a. Did you receive any of the following at this hospital? These questions are to ascertain whether the participant has received a diagnosis of Lung Cancer or other cancer or if they have had any Lung or Chest treatments of any kind. Respond with Yes, No, or I'm not sure for each answer.

Diagnosis of Lung Cancer
Treatment for Lung Cancer
Care related to a lung or chest condition
Care for complications from a lung or chest procedure
Diagnosis of any other cancer. If yes, please specify the type of cancer below.

b. Did you have any of the following procedures at this hospital? These questions are to ascertain whether the participant has had any procedures relating to Lung, Chest or Cancer diagnoses. A list of the most frequent tests done for Lung Cancer/Chest Disease work up is listed. Please indicate yes or no for each test or therapy listed.

Chest X-Ray
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Nuclear Medicine scan of chest, lungs, or heart
Surgery to chest or lungs
Biopsy of chest or lung
Bronchoscopy (tube inserted in airways to study lungs)
Lung cancer chemotherapy
Lung cancer radiation therapy
Other lung test or lung cancer therapy, specify other test below

c. Were you hospitalized at another facility? Please answer yes or no if you have been to any other hospital. Another FH form will be required if more hospitals were visited during this time period.
Participant Signature. If the participant completes the form via mail or live interview they must sign the form. If the form is completed via phone no signature is required but site RA’s should note in the signature space that the form was completed by phone.

Date Form Completed: This date is required for all forms regardless of who completes the form.