OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL Visit 2 Participant Disability Screening Form

ID NUMBER:									FORM CODE: PDE VERSION: 1, 9/10/2014	Contact Occasion	0	2	SEQ #	0	1

ADMINISTRATIVE INFORMATION

0a. Completion Date (mm/dd/yyyy): ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

***Instructions**: This disability screening form must be completed after informed consent administration and before the participant has their examination. Positive responses to Questions 1 – 6 should be noted on the Exam Itinerary Checklist for routing purposes during the visit.*
Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.

***Introductory Script for staff**:*

Now I would like to ask you about difficulties you may have in usual activities of daily living:

A. Disability Status	**No**	**Yes**
1. Are you deaf or do you have serious difficulty hearing?	0 ☐	1 ☐
2. Are you blind or do you have serous difficulty seeing, even when wearing glasses?	0 ☐	1 ☐
3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	0 ☐	1 ☐
4. Do you have serious difficulty walking or climbing stairs?	0 ☐	1 ☐
5. Do you have difficulty walking a half mile (approximately 1 kilometer)?	0 ☐	1 ☐
6. Do you have difficulty climbing 10 steps?	0 ☐	1 ☐
7. Do you have difficulty dressing or bathing?	0 ☐	1 ☐
8. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	0 ☐	1 ☐