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

HCHS/SOL Visit 2 Participant Safety Screening Form

| ID NUMBER: | | | | | | | | FORM CODE: PSE VERSION: 1, 9/18/2014 | Contact Occasion | 0 | 2 | SEQ # | 0 | 1 |

ADMINISTRATIVE INFORMATION

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

0c. Participant Gender: (1=Male, 2=Female,) ☐   0d. Age: ☐☐

Instructions: *This safety screening form must be completed before the participant can have their Visit 2 Examination either during a reminder phone call for the clinic visit, or immediately prior to the exam. Positive responses to Questions 2 – 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.

NOTE TO STAFF: Use appropriate clinic scheduling script when completing this form.

A. Safety and Access Questions

1. FEMALES only: Are you pregnant? [*MUJERES solamente: ¿Está embarazada*?]

    No   0 ☐

    Yes   1 ☐ → **STOP, reschedule visit after delivery**

2. Do you need any kind of assistance reading, hearing questions, or getting on an examination table? [*¿Necesita algún tipo de ayuda para leer, escuchar preguntas o para subirse a una camilla de reexaminación* ?]

    No   0 ☐ → **GO to Question 3**

    Yes   1 ☐ → **GO to Question 2a**

    2a. Specify: _____

3. Do you have either a heart pacemaker or defibrillator (AICD)? [*¿Tiene un marcapaso o defribilador (AICD por sus siglas en inglés?*]

    No   0 ☐

    Yes   1 ☐ → **Exclude from BIA**

4. Has a doctor or health professional ever told you that you have diabetes (high sugar in blood or urine)? [*¿Alguna vez le ha dicho un doctor que usted tiene diabetes (azúcar alta en la sangre o en la orina)?*]

    No   0 ☐

    Yes   1 ☐ → **Exclude from OGTT**

B. Echocardiography Exam Exclusion Questions

5. Did this person participate in the HCHS Echo ancillary study?

No   0 ☐

Yes   1 ☐ → **Echo Exam Exclusion**

C. Other Exclusion(s)

6. Specify condition or circumstance: _____

    6a. Procedure(s)/test(s) excluded: _____

    6b. Name or Staff ID authorizing this exclusion: ☐☐☐ _____

Record ALL Yes **responses to Questions 2-6 on the Exam Itinerary Checklist form**