

S1316 Dietary Recall Contact Form

Instructions: This form will be used by the Arizona Diet, Behavior, and Quality of Life Assessment Lab to contact the patient to conduct the S1316 24-hour dietary recalls.

Email this form to the Arizona Diet, Behavior, and Quality of Life Assessment Lab within 24 hours after registration to S1316. **Always follow your institutional HIPAA policies for emailing PHI.**

You must use the following address to submit this form: UACC-MBO@uacc.arizona.edu

Patient First Name and Last Name Initial: _____

Site Name _____ SWOG Site # or NCI code: _____

Name of Nurse/CRA who will be contacting this patient for weekly site calls: _____ Patient's preferred language:

_____ English Spanish

SWOG ID: _____ Registration Date: _____

Phone # (best): (___) ___ - ___ - ___ Cell / Land Time Zone (Please circle): ET CT MT PT

Phone Number (alt): (___) ___ - ___ - ___ Cell / Land Time Zone (Please circle): ET CT MT PT

Full name of an authorized alternate contact who could respond to dietary questions (always provide):

Alternate's contact phone number (best): (___) ___ - ___ - ___ Cell / Land

Alternate's Email address: _____

NOTES re: Alternate Contact: _____

DO NOT CALL THE PATIENT if this box is marked; use the authorized alternate contact for the information.

Preferred time to call (place "yes" in available times):

Time	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning - Anytime							
7 - 9 AM							
9 - 11 AM							
11 - noon							
Afternoon - Anytime							
Noon - 2 PM							
2 - 4 pm							
4 - 6 pm							
Evening							
6 - 8 pm							
Other							