**CBCS3 Follow Up #12 (13/14-year) Telephone Call Log**

|  |  |
| --- | --- |
| Name: «FNAME» «LNAME» | AGE: «SUBJECT\_CURRENT\_AGE» |
| Address: «ADDR1» «ADDR2» «CITY» «STATE» «ZIP» | In-home interview date: «NURSE\_VISIT\_DATE»Eligibility date: «CCR\_FIRST\_ELIG\_DATE» |
| 1st Phone #: «PHONE1» | DOB: «DOB»  |
| 2nd Phone #: «PHONE2» | Email: «EMAIL\_ADDR» |
| Gift Card Code: «GIFT\_CARD\_PIN» | Last Date of Contact: |

**COMMENTS:** «SUBJECT\_ADDR\_COMMENTS»; «SUBJECT\_COMMENTS»

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Call # | Initials | Date | Time | Contact Method | \*Result | Comments |
| 1. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 2. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 3. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 4. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 5. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 6. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 7. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 8. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 9. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 10. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 11. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 12.  |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 13. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |
| 14. |  |  | \_\_\_\_\_:\_\_\_\_\_ AM / PM |  |  |  |

\*Results: NA=No Ans.; NH=Not Home; LVM=Left Voice Mail; CB=Call Back; R=Refused; NFC=No Further Contact; CC=Call Completed

**NOTES:**

|  |  |
| --- | --- |
| Name: «FNAME» «LNAME» | AGE: «SUBJECT\_CURRENT\_AGE» |
| Address: «ADDR1» «ADDR2» «CITY», «STATE» «ZIP» | In-home interview date: «NURSE\_VISIT\_DATE»Eligibility date: «CCR\_FIRST\_ELIG\_DATE» |
| 1st Phone #: «PHONE1» | DOB: «DOB»  |
| 2nd Phone #: «PHONE2» | Email: «EMAIL\_ADDR» |
| Gift Card Code: «GIFT\_CARD\_PIN» | Last Date of Contact: |

**COMMENTS:** «SUBJECT\_ADDR\_COMMENTS»; «SUBJECT\_COMMENTS»

**ADDRESS HISTORY** (Obtain history since last contact making sure to collect all addresses. Enter in Address History tab in CBCS database for FU#12.)

**READ: Please let me double-check your mailing address and phone number. I have it as «ADDR1», «ADDR2», «CITY», «STATE», and your phone number(s) as «PHONE1» (and «PHONE2»)?**

**A. Is this still the correct contact information for you?** 1\_\_\_YES **à** GO TO **C**

 (*Review address and telephone contact info printed above.*) 2\_\_\_NO

**B. (**Choose one: **What is your preferred mailing address?** *or* **What is(are) your new phone number(s)?** *or* **What is your new contact information?)**

 **Street Address:**

 **City, State, ZIP:**

 **Phone 1:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone 2:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cell  Home  Work  Cell  Home  Work

**C. Is this also your physical address? If YES à** GO TO **READ**

**If NO, record on separate page. Transfer to Comments after survey.**

(*If both telephone and address are incorrect, please ask participant to provide age or birthday (month/day only) to confirm correct identity.* Do not provide DOB to them*!*)

**D. When did you begin living at this address?** \_\_\_\_\_\_\_\_\_\_, \_\_\_ \_\_\_ \_\_\_ \_\_\_

(*Calculate number of years at current address.*) (Month) (Year)

**So, you’ve been living at this address continuously for about \_\_\_ \_\_\_ years?**

**If value GREATER THAN years since last contact, à** GO TO **READ**

**If value LESS THAN years since last contact, à** GO TO **E**

**E. What was your previous address?**

1st Previous Address:

City, State, ZIP:

**When did you live at this address?** \_\_\_\_\_\_\_\_\_\_, \_\_\_ \_\_\_ \_\_\_ \_\_\_ TO \_\_\_\_\_\_\_\_\_\_, \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year) (Month) (Year)

(*If SUM of D+E is LESS THAN the number of years since last contact, obtain full address history on separate sheet of paper. Transfer to Address History tab in database after interview is completed*.)

**READ:** Thanks! Okay, let’s get started. **(Return to Follow-up #12 Telephone survey, p. 1)**

**CBCS3 Follow Up #12 (13/14-Year) Telephone Survey**

|  |  |
| --- | --- |
| Name: «FNAME» «LNAME» | Collected by (initials): |
| DOB: «DOB» AGE: «SUBJECT\_CURRENT\_AGE» | Date Collected: \_\_\_ \_\_\_ /\_\_\_ \_\_\_ /\_\_\_ \_\_\_ |
| Date of Elig: «CCR\_FIRST\_ELIG\_DATE» | Start Time: \_\_\_ \_\_\_ : \_\_\_ \_\_\_ am / pm |
| Date of FU#10: « E150\_DATE\_UPDATE » | Last Date of Contact:  |

 **READ:** Thank you for agreeing to talk with me about your breast cancer experience. All of the information you share with me today will be kept confidential, and it should only take about 20 minutes. You do not have to answer any questions that you don’t want to answer. Just let me know if you want to skip a particular question and we’ll move on to the next question. We’ll also send you payment of **$10** within 4 weeks of completing this call. Do you have any questions before we begin?

**VERIFY PARTICIPANT’S ADDRESS/CONTACT INFO:** (See **Call Log**, pg. 1, for script.)

**** Verified, No Changes **** Verified w/Changes

**READ:** The last time we talked, we reviewed your breast cancer treatment history. I’d like to go over that with you now in order to update your treatment information.

(*See HP sheet. Review for information about previous recurrences/2nd primaries. Note whether additional Medical Records are still needed from previous contacts*.)

**1. Since we last spoke**, have you had a (*or*, another) **recurrence** of your breast cancer?

1\_\_\_\_YES 2\_\_\_\_NO à SKIP TO **Q2** 9\_\_\_\_NA or Don’t Know à SKIP TO **Q2**

**1a.** When was the recurrence? \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year)

**1b.** In what part of your body?

**1c.** How were you diagnosed? (**Read options**; check all that apply.)

a Blood test

b Biopsy or surgery

c Imaging (ultrasound, PET scan, CAT scan, X-ray)

d Other:

**Please tell me about any surgical procedures you have had for this recurrence.**

|  |
| --- |
| **1st Surgical Procedure for Recurrence:****SCHEDULED** or **ACTUAL** SurgicalProcedure Date: (Circle “Scheduled” or “Actual” above.)Procedure Type(s): Facility/Clinic Name/Address: Medical Provider Name/Address: Comments:   |

Did you have another surgical procedure for the recurrence, or do you have any procedures scheduled? Y N

|  |
| --- |
| **2nd Surgical Procedure for recurrence** **SCHEDULED** or **ACTUAL** SurgicalProcedure Date: (Circle “Scheduled” or “Actual” above.) Procedure Type(s): Facility/Clinic Name/Address: Medical Provider Name/Address: Comments:   |

**1d.** Have you received any treatment(s) for the recurrence? 1\_\_\_\_YES

2\_\_\_\_NO à SKIP TO **Q2**

**1st Treatment/Procedure:** Type(s) for Recurrence:

1st Treatment or Procedure Start Date:

 **Is treatment completed or ongoing or stopped?**

1\_\_\_\_COMPLETED 2\_\_\_\_ONGOING 3\_\_\_\_STOPPED BEFORE IT WAS COMPLETED

**If completed or stopped:** Completion/Stop Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year)

Medical Provider Name:

MD/Facility/Clinic Name:

Address:

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ \_\_\_ Zip: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

COMMENTS:

**2nd Treatment/Procedure:** Type(s) for Recurrence:

2nd Treatment or Procedure Start Date:

 **Is treatment completed or ongoing or stopped?**

1\_\_\_\_COMPLETED 2\_\_\_\_ONGOING 3\_\_\_\_STOPPED BEFORE IT WAS COMPLETED

**If completed or stopped:** Completion/Stop Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year)

Medical Provider Name:

MD/Facility/Clinic Name:

Address:

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ \_\_\_ Zip: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

COMMENTS:

**2. Since we last spoke**, have you been diagnosed with a (*or*, another) **new breast tumor**? (*If necessary*:) This means you had a new breast tumor in a new area on the same breast or in the other breast—some people call this a “second primary.”

**Notes for Caller:** Location of 1st Primary: «BREAST\_LATERALITY\_DESC»

1\_\_\_\_YES 2\_\_\_\_NO à SKIP TO **Q3** 9\_\_\_\_NA or Don’t Know à SKIP TO **Q3**

**2a.** When were you diagnosed with the new breast tumor? \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year)

**2b.** Was in the same breast or in the other breast?

**** Same **** Other

**2c.** How were you diagnosed? (**Read options**; check all that apply.)

a Blood test

b Biopsy or surgery

c Imaging (ultrasound, PET scan, CAT scan, X-ray)

d Other:

**Please tell me about any surgical procedures you have had for this new tumor.**

|  |
| --- |
| **1st Surgical Procedure for New Breast Primary:****SCHEDULED** or **ACTUAL** SurgicalProcedure DATE: (Circle “Scheduled” or “Actual” above)Procedure type(s): Facility/Clinic Name/Address: Medical Provider Name/Address: COMMENTS:   |

Did you have another surgical procedure for the new tumor, or do you have any procedures scheduled? Y N

|  |
| --- |
| **2nd Surgical Procedure for New Breast Primary:****SCHEDULED** or **ACTUAL** SurgicalProcedure DATE: (Circle “Scheduled” or “Actual” above)Procedure type(s): Facility/Clinic Name/Address: Medical Provider Name/Address: COMMENTS:   |

**2d.** Have you received any treatment(s) for the new breast tumor? 1\_\_\_\_YES

 2\_\_\_\_NO à SKIP TO **Q3**

**1st Treatment/Procedure:** Type(s) for New Tumor:

1st Treatment or Procedure Start Date:

 **Is treatment completed or ongoing or stopped?**

1\_\_\_\_COMPLETED 2\_\_\_\_ONGOING 3\_\_\_\_STOPPED BEFORE IT WAS COMPLETED

**If completed or stopped:** Completion/Stop Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year)

Medical Provider Name:

MD/Facility/Clinic Name:

Address:

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ \_\_\_ Zip: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

COMMENTS:

**2nd Treatment/Procedure:** Type(s) for New Tumor:

 2nd Treatment or Procedure Start Date:

 **Is treatment completed or ongoing or stopped?**

1\_\_\_\_COMPLETED 2\_\_\_\_ONGOING 3\_\_\_\_STOPPED BEFORE IT WAS COMPLETED

**If completed or stopped:** Completion/Stop Date: \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year)

Medical Provider Name:

MD/Facility/Clinic Name:

Address:

 City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_ \_\_\_ Zip: \_\_\_ \_\_\_ \_\_\_ \_\_\_ \_\_\_

COMMENTS:

**3. Since we last spoke**, have you been told by a Medical Provider that you had cancer in a place other than your breasts? (If possible, verify that this is for a new cancer, and not for a recurrence or metastasis. If recurrence or metastasis, record treatment info in questions 1-2.)

1\_\_\_\_YES 2\_\_\_\_NO à SKIP TO **Q5a** 9\_\_\_\_NA or Don’t Know à SKIP TO **Q5a**

|  |  |  |
| --- | --- | --- |
| **4.**  | **a.** What type of cancer did you have? | **b.** What year was this cancer diagnosed?  |
| 1st Diagnosis |  |  |
| 2nd Diagnosis |  |  |
| 3rd Diagnosis |  |   |

(9999 if Don’t Know)

(**Data Entry Note**: If other cancer is reported, please record type and

date in a FU#12 Health Prof tab. Update to “MR not needed.”)

**5a. (Review HP Form with participant and provide an update with latest treatment information.)** Since the last time we spoke, are there any other health care providers (physician, clinic, hospital, etc.) who treated you or followed up with you, or whom you are scheduled to see, for follow-ups, treatment or surgery related to breast cancer? This may include follow-up office visits with your surgeon or plastic surgeon, oncologist or Medical Provider, radiation oncologist, or primary care physician, including procedures or treatments for your initial diagnosis. This may also include the start of new medications related to your breast cancer treatment, such as hormone therapy.

1\_\_\_\_YES 2\_\_\_\_ NO à SKIP TO **Q6**

**1st New Visit/other Treatment or Procedure not previously listed on HP Report**

**SCHEDULED** or **ACTUAL** Treatment/Visit Date:

(Circle “Scheduled” or “Actual” above.)

Purpose of Visit:

*If Follow-up or annual visit, ask*: Was this a routine follow-up, or did the Medical Provider address a specific health issue or problem you were having? \_\_\_ Routine Visit \_\_\_ Problem

(Specify, if problem):

Treatment for: \_\_\_ Initial Diagnosis \_\_\_\_ Recurrence \_\_\_\_ New Primary

Facility/Clinic Name/Address:

(Ordering) Medical Provider Name/Address:

Medical Provider/Facility Tel.

COMMENTS:

**5b.** Have you had any additional cancer related visits, treatments or procedures not already mentioned?

1\_\_\_\_YES 2\_\_\_\_ NO à SKIP TO **Q6**

**2nd New Visit/other Treatment or Procedure not previously listed on HP Report**

**SCHEDULED** or **ACTUAL** Treatment/Visit Date:

(Circle “Scheduled” or “Actual” above.)

Purpose of Visit:

If Follow-up or annual visit, ask: Was this a routine follow-up, or did the Medical Provider address a specific health issue or problem you were having? \_\_\_ Routine Visit \_\_\_ Problem

(Specify, if problem):

Treatment for: \_\_\_ Initial Diagnosis \_\_\_\_ Recurrence \_\_\_\_ New Primary

Facility/Clinic Name/Address:

(Ordering) Medical Provider Name/Address:

Medical Provider/Facility Tel.

COMMENTS:

**5c.** Have you had any additional cancer-related visits, treatments or procedures not already mentioned?

1\_\_\_\_YES 2\_\_\_\_ NO

**3rd New Visit/other Treatment or Procedure not previously listed on HP Report**

**SCHEDULED** or **ACTUAL** Treatment/Visit Date:

(Circle “Scheduled” or “Actual” above.)

Purpose of Visit:

If Follow-up or annual visit, ask: Was this a routine follow-up, or did the Medical Provider address a specific health issue or problem you were having? \_\_\_ Routine Visit \_\_\_ Problem

(Specify, if problem):

Treatment for: \_\_\_ Initial Diagnosis \_\_\_\_ Recurrence \_\_\_\_ New Primary

Facility/Clinic Name/Address:

(Ordering) Medical Provider Name/Address:

Medical Provider/Facility Tel.

COMMENTS:

**6. (If no end date to hormone therapy in Subject Treatment History.)** The last time we spoke, you told us you were taking *(hormone therapy)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in (month/year)\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_.

 Are you still on this(these)? 1\_\_\_\_YES 2\_\_\_\_ NO 9\_\_\_\_ N/A or Don’t Know

 When did you (check one:) **** complete / **** stop / **** change treatment?

 \_\_\_ \_\_\_ / \_\_\_ \_\_\_ \_\_\_ \_\_\_

 (Month) (Year)

 IF CHANGED: What new hormone therapy are you on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.** **(SKIP if NO to Q1, Q2, and Q5a-c *and* YES to Q6.)** With your permission, we may want to request copies of your medical records from the Medical Providers and hospitals you mentioned (**if YES to Q1 or Q2:** and to request samples of the diagnostic surgeries or procedures for your [recurrence/new breast primary] to compare with the tissue we have from your original diagnosis.) We’d like to mail the consent forms to you along with a pre-paid business reply envelope. If you sign the forms and mail them, we’ll send you payment for **$15** (**if YES to Q1 or Q2:** **$30** for both consents). It’s okay if you choose not to give us permission to get copies of your medical records; you can still participate in the study.

**May I send the consent forms to you for your signature?** 1\_\_\_\_YES 2\_\_\_\_NO

(If **YES**, circle YES on checklist (last page of survey) next to “Medical Records consents only.”)

**8.** **Since the last time we spoke**, have you been told by a Medical Provider or other health professional that you have a new medical condition?

(Note: Answers re: health conditions from FU6, FU7, FU9, and FU10 are included in folder.)

1\_\_\_\_YES 2\_\_\_\_NO à SKIP TO **Q10** 9\_\_\_\_NA or Don’t Know à SKIP TO **Q10**

| IF YES: **9a. What medical condition were you diagnosed with?***If participant doesn’t know what a medical condition is, read list*: Dementia, arthritis, asthma COPD, diabetes, HIV/AIDs, hypertension, kidney failure, cirrhosis or liver disease, osteoporosis, inflammatory bowel disease, ulcer, anxiety, depression, bipolar disorder, schizophrenia, congestive heart failure, angina/chest pain, heart attack, high cholesterol, stroke, blood clots in leg or lungs, thyroid problem), neuropathy, or any other condition? | **9b.** What year was this condition diagnosed? | **9c.** Do you currently take any prescription medications for this condition? |
| --- | --- | --- |
| 1st new medical condition: (describe) | (DK: 9999) | 1\_\_\_\_Yes2\_\_\_\_No |
| 2nd new medical condition: (describe) | (DK: 9999) | 1\_\_\_\_Yes2\_\_\_\_No |
| 3rd new medical condition: (describe) | (DK: 9999) | 1\_\_\_\_Yes2\_\_\_\_No |
| 4th new medical condition: (describe) | (DK: 9999) | 1\_\_\_\_Yes2\_\_\_\_No |

**READ:** Next I want to ask some questions about lifestyle.

To be used only as prompt if participant cannot recall answers to Q10 &/or Q11.

Weight at FU#10: «FU10\_REPORTED\_WEIGHT» lbs.

**10.** How much do you currently weigh? \_\_\_ \_\_\_ \_\_\_ lbs.(enter 888 if Don’t Know/Refused)

**11.** Have you gained or lost more than 5 pounds in the past two years?

 (1)\_\_\_\_ YES (2)\_\_\_\_ NO **à** SKIP TO **Q12** (9)\_\_\_\_ Don’t Know **à** SKIP TO **Q12**

**11a.** \_\_\_\_Gained: How much? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ lbs**.**

**11b.** \_\_\_\_Lost:How much? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ lbs**.**

**12.** Since we last spoke, have you smoked cigarettes?

(1)\_\_\_\_ YES, and I still smoke.

(2)\_\_\_\_ YES, but I have quit. **à** SKIP TO **Q13**

(3)\_\_\_\_ NO **à** SKIP TO **Q13**

(9)\_\_\_\_ Don’t Know/Refused to Answer **à** SKIP TO **Q13**

**12a.** On average, how many cigarettes do you smoke per day? (*20 cigs/pk*)

(1)\_\_\_\_ More than 2 packs (6)\_\_\_\_ Once in a while, not every day

(2)\_\_\_\_ >1½ to 2 packs (9)\_\_\_\_ NA

(3)\_\_\_\_ >1 to 1½ pack

(4)\_\_\_\_ ½ to 1 pack

(5)\_\_\_\_ Less than ½ pack

**13.** Do you currently drink alcoholic beverages?

(1)\_\_\_\_ YES (2)\_\_\_\_ NO **à** SKIP TO **Q14** (9)\_\_\_\_ Don’t Know **à** SKIP TO **Q14**

**13a.** On average, how many drinks containing alcohol do you have each **week**? (*Optional:* **By one drink, we mean, for example, a 12-ounce can or glass of beer or cooler, a 5-ounce glass of wine, or a drink containing 1 shot of liquor.**)

\_\_\_\_ \_\_\_\_ \_\_\_\_ drinks per week (*Enter “000” if less than 1 drink per week.)*

**READ:** Now I am going to ask you a couple questions about your physical activity since we last spoke to you. I am going to ask about moderate and vigorous physical activity.

**14. Moderate** **activities cause your heart rate and your breathing to go up just a little bit.** How many days per week do you do moderate physical activity for at least 10 minutes at a time?

 \_\_\_\_ Days per week *(Enter 9 for Don’t Know/Refused to Answer.)*

**15. Vigorous activities cause a large increase in your heart rate and breathing rate.** How many days per week do you do vigorous physical activity for at least 10 minutes at a time?

 \_\_\_\_ Days per week *(Enter 9 for Don’t Know/Refused to Answer.)*

**16.** What type of health insurance do you have **now**? (Read options, check all that apply)

a None (Note: Include UNC Charity Care etc.)

b Private health insurance purchased on your own or by your husband or partner

c Private health insurance from your employer or workplace or that of your husband or partner (Note: Include former employer retirement healthcare, e.g., Tricare and State Employees)

d Medicaid

e Medicare

f Any other insurance that covers part of your medical bills (Note: Include healthcare sharing ministries)

g Not Answered or Unknown

**17. In the past two years**, was there a time when you did not have any health insurance?

(1)\_\_\_\_ YES (2)\_\_\_\_ NO **à** SKIP TO **Q18** (9)\_\_\_\_ Don’t Know **à** SKIP TO **Q18**

 **17a.** Did you lose your insurance as a result of the COVID-19 pandemic?

(1)\_\_\_\_ YES (2)\_\_\_\_ NO (9)\_\_\_\_ Don’t Know

**17b.** Combining all of the times that you were without coverage in the last two years, what was the total amount of time that you did not have health insurance?(*Enter years and months. Enter 00 if none and 99 if Don’t Know/Refused to Answer.*)

 \_\_\_\_ \_\_\_\_ Years \_\_\_\_ \_\_\_\_ Months

**READ:**            In this final section, we will ask about your thoughts regarding how you are treated in your day-to-day life and related to healthcare. We are interested in the experiences of breast cancer survivors across different parts of their lives. In your day-to-day life, how often do any of the following things happen to you?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|   | **(5)****Almost every day** | **(4)****At least once a week** | **(3)****A few times a month** | **(2)****A few times a year** | **(1)****Less than once a year** | **(0)****Never** | **(9)****Don’t Know/ Refuse** |
| **18a.** | You are treated with less courtesy than other people are. |  |  |  |  |  |  |  |
| **18b.** | You are treated with less respect than other people are. |  |  |  |  |  |  |  |
| **18c.** | You receive poorer service than other people at restaurants or stores. |  |  |  |  |  |  |  |
| **18d.** | People act as if they think you are not smart. |  |  |  |  |  |  |  |
| **18e.** | People act as if they are afraid of you. |  |  |  |  |  |  |  |
| **18f.** | People act as if they think you are dishonest. |  |  |  |  |  |  |  |
| **18g.** | People act as if they’re better than you are. |  |  |  |  |  |  |  |
| **18h.** | You are called names or insulted. |  |  |  |  |  |  |  |
| **18i.** | You are threatened or harassed. |  |  |  |  |  |  |  |

If all answers are these answers,

à GO TO **Q20**

If 1 or more of these answers is given,

à GO TO **Q19**

**19.** You answered “A few times a year” or more frequently to (*count*) \_\_\_ statements above, what do you think is a reason for these experiences? (*Read the list. Check all that apply*.)

 **19a.** \_\_\_\_ Your ancestry or national origins

 **19b.** \_\_\_\_ Your gender

 **19c.** \_\_\_\_ Your race

 **19d.** \_\_\_\_ Your age

**19e.** \_\_\_\_ Your religion

 **19f.** \_\_\_\_ Your height

 **19g.** \_\_\_\_ Your weight

 **19h.** \_\_\_\_ Some other aspect of your physical appearance

 **19i.** \_\_\_\_ Your sexual orientation

 **19j.** \_\_\_\_ Your education or income level

 **19k.** \_\_\_\_ Other:

**READ:**            The next questions ask how you feel about parts of healthcare organizations. Please answer the following statements with your level of agreement. Do you Strongly Disagree, Disagree, Agree, or Strongly Agree?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **(1)****Strongly Disagree** | **(2)****Disagree** | **(3)****Agree** | **(4)****Strongly Agree** | **(9)****Don’t Know/ Refused** |
| **20a.** | You should be cautious when dealing with healthcare organizations. |  |  |  |  |  |
| **20b.** | Patients have sometimes been deceived or misled by healthcare organizations. |  |  |  |  |  |
| **20c.** | When healthcare organizations make mistakes they usually cover it up. |  |  |  |  |  |
| **20d.** | Healthcare organizations have sometimes done harmful experiments on patients without their knowledge. |  |  |  |  |  |
| **20e.** | Healthcare organizations don’t always keep your information totally private. |  |  |  |  |  |
| **20f.** | Sometimes I wonder if healthcare organizations really know what they are doing.  |  |  |  |  |  |
| **20g.** | Mistakes are common in healthcare organizations. |  |  |  |  |  |

**READ:** People interact with doctors and hospitals when a cancer diagnosis occurs… and also for many other reasons not related to cancer. The next questions ask about your perspective on race and interactions with healthcare organizations. Please answer the following statements with your level of agreement:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **(1)****Strongly Disagree** | **(2)****Disagree** | **(3)****Agree** | **(4)****Strongly Agree** | **(9)****Don’t Know/ Refused** |
| **21a.** | Doctors treat Black and White people the same. |  |  |  |  |  |
| **21b.** | Racial discrimination in a doctor’s office is common. |  |  |  |  |  |
| **21c.** | In most hospitals, Black and White people receive the same kind of care. |  |  |  |  |  |
| **21d.** | Black people can receive the care they want as equally as White people can. |  |  |  |  |  |

**READ:** Thank you for answering the questions in this survey.

**22a.** We want to let you know that we so appreciate the time and energy you have given over the past (thirteen/fourteen) years. As we continue to study the experiences of long-term breast cancer survivors, would you be willing to be contacted in future follow-ups?

(1)\_\_\_\_ YES

(2)\_\_\_\_ MAYBE/I’M NOT SURE

(3)\_\_\_\_ NO **à** SKIP TO **Q24**

**READ: 22b.** You previously gave us your consent to contact [*read name(s) and phone number(s) from Other Contacts Sheet*]. (Is this/are these) the best contact(s) for you still?

(1)\_\_\_\_ YES **à** SKIP TO **Q24**

(2)\_\_\_\_ NO

**READ:**  Who is the best person to contact?

**23a.** 1st contact:

Name: Relationship:

Address:

Phone number(s): E-mail address:

**23b. Is there a 2nd contact?**

Name: Relationship:

Address:

Phone number(s): E-mail address:

[**NOTE:** If this participant had *not* completed the *Addendum to provide additional information to subject after original consent prior*, go to the separate page. See Comments for notation. Read consent addendum here, and then delete that comment for future follow-ups.]

**24.** Do you have any questions or comments before we end?

 (1)\_\_\_\_ YES (2)\_\_\_\_ NO

 (*Answer general questions about the study only. For medical questions, refer them to their physician*.)

**ENDING:** That’s it! Thank you for completing this call. You should be receiving a mailing from us within 4 weeks, including a gift card for **$10** to thank you for taking the time to complete this follow up call with us. With your help we have added to our understanding about lifestyle, treatment, and other factors affecting breast cancer outcomes. A huge thanks to you for making this study possible. On behalf of the Carolina Breast Cancer Study, we wish you all the best.

**Interview Call End time: \_\_\_\_ \_\_\_\_ : \_\_\_\_ \_\_\_\_ am / pm**

|  |
| --- |
| **CHECKLIST FOR MAILING** (REVIEW WITH STUDY PARTICIPANT)(If YES to any other items below, please mention that they may be in the mailing, as well as business reply envelope.)**Consent addendum (COPY ONLY)**  **YES NO****Medical records consents only (no block consents)** (2 copies)  **YES NO****Medical records/Tumor block consents** (2 copies)  **YES NO****New consent form for additional tissue specimen** (2 copies) **YES NO****Other?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **YES NO** |

Notes:

**** Participant requests that we donate the $10 payment to the Carolina Breast Cancer Study.

**(NEVER read aloud to participant.)**