

Form A

Participant ID # _____

THE VETERANS HEALTH STUDY
CENTERS FOR DISEASE CONTROL
ATLANTA, GEORGIA 30333
(404) 454-4472

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby grant permission for representatives of the Centers for Disease Control (CDC) to review, abstract or receive copies of medical charts and records pertaining to my child: _____

(Name of Child)

These records and charts are located at:

This authorization for the release of medical records will be considered valid for the duration (March 15, 1986-June 15, 1987) of the study in order for CDC researchers to confirm the presence or absence of serious health problems evident at birth in my child.

The promise of complete confidentiality is contained in Section 308(d) of the Public Health Service Act (42 U.S.C. 242m(d)). The identity of both the parent signing this form and the institution providing the records, along with the child's medical record itself, will not be disclosed to anyone outside the U.S. Public Health Service or the private research firms working on this study. Unless you give written permission to the Centers for Disease Control to release information, no one, including your family, will ever be able to obtain personal information concerning you or your child. This information will be used solely for the scientific purposes of the study and no personal identifiers will be used in any study report. No individually identified information will be disclosed to any other researchers or government agencies, including the Veterans Administration and the Department of Defense. Your decision to release these records is voluntary and will not affect any benefits you may be receiving or to which you may be entitled in the future. However, access to your child's medical records will enable CDC researchers to prepare a more accurate report and greater credibility will be given to the study results.

In signing this authorization, I recognize that CDC will inform the hospital that this request for records is part of its nationwide study of Vietnam-era U.S. Army veterans. Such information will identify me, indirectly, to the hospital as a participant in this study.

Signed _____

Name (Printed) _____

Relationship to Child _____

Date _____

Form B

HOSPITAL LETTER

Dear Director:

The Centers for Disease Control (CDC) of the U.S. Public Health Service is conducting a nationwide health study of Vietnam-era Army veterans that was mandated by Congress. As part of the study, CDC wants to confirm the presence or absence of serious health problems evident at birth among offspring of veterans. To achieve this goal, we are requesting hospitals to provide us with copies of children's medical records covering their birth and associated hospital stay.

Enclosed is a FACT SHEET for a child who was born at your hospital and a signed AUTHORIZATION TO RELEASE MEDICAL RECORDS form (valid - March 15, 1986-June 30, 1987) from the father or mother. We would appreciate receiving a copy of the child's entire medical record covering the birth and associated hospital stay. We are especially interested in the following:

- a. discharge summary
- b. birth certificate work sheet
- c. progress notes
- d. diagnostic test results
- e. delivery room record
- f. pathology/autopsy findings and consultations
- g. physical exam

Please attach this information to a copy of the FACT SHEET for return.

In accordance with Section 308(d) of the Public Health Service Act (42 U.S.C. 242m(d)), all information sent to us will be kept strictly confidential. This is your assurance that the medical records will be used solely for the purposes of this research project. No personal identifiers will be used in any report from this study. In addition, this assurance of confidentiality extends to the identity of the institution providing information to CDC.

For your convenience, we have enclosed a self-addressed, postage and fees paid label to use in mailing us copies of the appropriate records.

If you have any questions, please contact me at (404) 454-4468.

Sincerely yours,

Linda Moyer, R.N.
Veterans Health Study

Enclosures

Form C

FACT SHEET FOR HOSPITALS

******PLEASE RETURN WITH MEDICAL RECORDS******

NAME OF HOSPITAL (WHERE CHILD WAS BORN):

NAME OF CHILD (LAST, FIRST, MIDDLE):

DATE OF BIRTH:

FATHERS NAME AT BIRTH (LAST, FIRST NAME):

FATHERS SSN:

MOTHERS NAME AT BIRTH (LAST, FIRST NAME):

MOTHERS MAIDEN NAME:

HOSPITAL WHERE TRANSFERRED (CITY, STATE):

FOR CDC USE ONLY:
PARTICIPANT ID #:
INTERVIEW DATE:

LEAD LETTER TO VETERANS

On behalf of the Centers for Disease Control (CDC), I would like to thank you for your earlier participation in the Veterans Health Study. As you know, this survey is one of the largest scientific research projects ever conducted on the health of veterans. Your cooperation has been a valuable contribution to the study.

I would like to point out that CDC is concerned about not only the health of veterans such as yourself, but also the health of their children. Thus, we have begun a special in-depth study of a sample of children reported by veterans in their telephone interviews. You have been selected for this follow-up survey. We need to ask you for additional information about one or more of your children.

For certain children, we would like to know their FULL NAME, DATE OF BIRTH, HOSPITAL OF BIRTH AND LOCATION, NAME OF MOTHER, AND HER COMPLETE DATE OF BIRTH. If you are willing to provide these facts, we will ask for your written permission or the mother's permission to obtain a copy of the children's hospital birth records. In the event we are unable to obtain these records, we may request the children's birth or death certificate from the appropriate vital statistics office. We need to look at these records to do a comprehensive evaluation of the individual child's health status at birth.

As was the case with the previous interview to which you kindly responded, your participation in this portion of the study is completely voluntary. All information provided to CDC will be protected from disclosure by Federal law. This is your assurance that the requested records will be used solely for the research purposes of this study and that published reports will not contain personal identifiers.

We will be calling you within the next week. The questions should take only about 10 to 15 minutes of your time. If you have changed your telephone number since your first interview or do not have a telephone at home, you may call Mrs. Linda Moyer collect at (404) 454-4468. Again, I would like to thank you for your cooperation in the study and hope that you will be able to help us once more.

Sincerely,

Robert M. Worth, M.D., Ph.D.
Veterans Health Study
Center for Environmental Health

Form E

BIRTH FACT SHEET - FOR FATHERS OF LIVE BORN CHILDREN

1. What was the child's full name at birth?

a. First Name

b. Middle Name

c. Last Name

2. What was the child's complete date of birth?

_____ Month

_____ Day

_____ Year

3. Where was the child born?

a. Name of Hospital or other Medical Facility

b. City (Town)

c. State (or Country)

If child was not born in a hospital, enter "not born in hospital" in Question 3d.

4. Was the child admitted to another hospital or readmitted to the birth hospital within one month following birth?

- 1 = No
- 2 = Yes
- 8 = Don't know
- 9 = Refused

If Q. 4 is other than "yes", Go to Q. 6.

5. What was the name and location of that hospital?

a. Name of Hospital

b. City (Town)

c. County (or Province)

d. State (or Country)

6. I need to know the full name of the child's mother when the child was born?

a. First name of mother

b. Middle name of mother

c. Last name of mother

d. Maiden name of mother

7. Finally, I need to know the mother's complete date of birth.

_____ Month
_____ Day
_____ Year

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Form F

BIRTH FACT SHEET - STILLBIRTHS (FOR MOTHERS)

1. First, I need to know your full current name.

a. First name of mother

b. Middle name of mother

c. Last name of mother

2. I also need to know the full name you had when the child was born and your date of birth.

a. First name of mother

b. Middle name of mother

c. Last name of mother

d. Maiden name of mother

e. Date of birth

3. What was the child's date of birth?

a. _____ Month

b. _____ Day

c. _____ Year

4. Where was the child born?

a. Name of Hospital or other Medical Facility

b. City (Town)

c. State (or Country)

If child was not born in a hospital, enter "not born in hospital" in Question 3d.

A/555

Form G

REFUSAL REPORT
THE CEREBROSPINAL MALFORMATIONS STUDY

// VETERAN
// WIFE/PARTNER

IDENTIFICATION

VETERAN SSN	ID	NAME	PHONE NUMBER
STREET ADDRESS		CITY	STATE ZIP

I. INITIAL REFUSAL DOCUMENTATION

A. Summarize respondent's stated objections to being interviewed.

B. Summarize your responses to the respondent's objections.

C. What was the strength of the refusal? (CIRCLE ONE.)

- 1 Mild-no hostility, good chance for conversion
- 2 Firm, but not hostile
- 3 Very firm and hostile

D. About which, if any, of the following topics did the respondent ask?
(CIRCLE ALL THAT APPLY.)

- | | |
|----------------------------|---------------------------------|
| 1 Purpose of the study | 6 Why he/she was selected |
| 2 Uses of the data | 7 How his/her name was obtained |
| 3 Confidentiality of data | 8 How we located him/her |
| 4 Why are we calling again | 9 Agent Orange relationship |
| 5 CDC | 10 Other (SPECIFY) _____ |

E. At what point during your contact did the initial objection occur?
(CIRCLE ONE.)

- | | |
|--------------------------------|--|
| 1 After "Hello" | 4 At end of introduction, but prior to beginning interview |
| 2 At beginning of introduction | 5 During interview-SPECIFY (1/#) _____ |
| 3 In middle of introduction | |

TELEPHONE INTERVIEWER NAME DATE OF REFUSAL TIME OF DAY (EDT)

APPENDIX E

Hospital Records Abstraction Form

14. Blank space /_/ (185)

RECORDS SENT 1=Yes 2=No

15. Face Sheet, Discharge Sheet,
Summary Record /_/ (186)

16. Labor & Delivery Record or
Summary /_/ (187)

17. Nursing Notes /_/ (188)

18. Physical assessment of
newborn /_/ (189)

19. Birth or Fetal Death Certificate Work Sheet /_/ (190)

20. Birth or Fetal Death Certificate /_/ (191)

21. Laboratory Findings /_/ (192)

22. Footprints, mother's thumb
print /_/ (193)

23. Mother's record, no separate
infant record /_/ (194)

24-25. Blank spaces /_/ /_/ /_/ /_/ /_/ (195-200)

34. Gravida (number of pregnancies including present (NR=99))		/ _ / _ /	(330-331)
35. Para (number of previous births excluding present) (NR=99)		/ _ / _ /	(332-333)
	Live births (NR=99)	/ _ / _ /	(334-335)
	Still births (NR=99)	/ _ / _ /	(336-337)
36. Abortions (NR=99)		/ _ / _ /	(338-339)
	Spontaneous (NR=99)	/ _ / _ /	(340-341)
	Induced (NR=99)	/ _ / _ /	(342-343)
37. Date of first day of last menstrual period (LMP)	Month	/ _ / _ /	(344-345)
	Day	/ _ / _ /	(346-347)
	Year	/ _ / _ /	(348-349)
38. Blood Group ABO (mother):		/ _ /	(350)
	1=A		
	2=B		
	3=AB		
	4=O		
	9=NR		
39. Rh (mother):		/ _ /	(351)
	1=Rh Positive		
	2=Rh Negative		
	9=NR		
40. Prenatal care	1=Yes 2=No 9=NR	/ _ /	(352)
41. Number of prenatal visits (NR=9), (8+=8)		/ _ /	(353)
42. Height			
	cms (NR=999)	/ _ / _ / _ /	(354-356)
	ft (NR=999)	/ _ / _ / _ /	(357-359)
43. Pre-pregnancy weight			
	kgs (NR=999)	/ _ / _ / _ /	(360-362)
	lbs (NR=999)	/ _ / _ / _ /	(363-365)

44. Weight gain during pregnancy		
kgs (NR=99)	/_/_/	(356-367)
lbs (NR=99)	/_/_/	(358-369)
Blank spaces	/_/_/	(370-371)
45. Pregnancy complications and illnesses		
1=Yes	/_/_/	(372)
2=No		
9=NR		
	ICD 9 Codes	
Specify _____	/_/_/_/_/	(373-376)
_____	/_/_/_/_/	(377-380)
_____	/_/_/_/_/	(381-384)
_____	/_/_/_/_/	(385-388)
_____	/_/_/_/_/	(389-392)
46. Previous maternal illnesses		
1=Yes	/_/_/	(393)
2=No		
9=NR		
	ICD 9 Codes	
Specify _____	/_/_/_/_/	(394-397)
_____	/_/_/_/_/	(398-401)
_____	/_/_/_/_/	(402-405)
_____	/_/_/_/_/	(406-409)
47. Labor		
1=Spontaneous	/_/_/	(410)
2=Induced		
8=NA		
9=NR		
48. If induced		
1= Pitocin	/_/_/	(411)
2=ROM		
3=Both		
4=Other, i.e. progestin suppositories		
8=NA		
9=NR		

49. Type of presentation		
1=Vertex	/_/_	(412)
2=Breech		
3=Other		
8=NA		
9=NR		
50. Type of delivery		
1=Vaginal, no forceps	/_/_	(413)
2=vaginal, forceps		
3=C-section		
4=vacuum extraction		
9=NR		
51. If C-section		
1=Elective	/_/_	(414)
2=Emergency		
8=NA		
9=NR		
Specify reason _____		
52. Anesthesia		
1=None	/_/_	(415)
2=Local		
3=General		
4=Spinal		
5=Epidural		
6=Other		
9=NR		
53. Complications of labor and delivery		
1=Yes	/_/_	(416)
2=No		
9=NR		
	ICD 9 Codes	
Specify _____	/_/_/_/_/_	(417-420)
_____	/_/_/_/_/_	(421-424)
_____	/_/_/_/_/_	(425-428)
_____	/_/_/_/_/_	(429-432)
_____	/_/_/_/_/_	(433-436)
54. Outcome of labor		
1=Live born	/_/_	(437)
2=Stillborn		
3=Induced abortion		
4=Miscarriage		
9=NR		

55-56. Blank spaces /_/_/_/ (4:18-440)

INFANT INFORMATION

57. Sex /_/_/ (4:1)
1=Male
2=Female
3=Ambiguous
9=NR

58. Race: /_/_/ (4:2)
1=White, not Hispanic 5=Oriental
2=Black 6=Hawaiian
3=Hispanic 7=Asian
4=American Indian 8=Other
9=NR

59. Plurality /_/_/ (4:3)
1=Single
2=Twin
3=Other multiple
9=NR

60. Birth weight /_/_/_/_/_/ (4:4-447)
grams (NR=99) /_/_/_/ (4:8-449)
lbs (NR=99) /_/_/_/ (4:0-451)
ozs (NR=99)

61. Head circumference /_/_/_/_/ (4:2-454)
mms (NR=999) /_/_/_/_/ (4:5-457)
inches*10 (NR=999)

62. Chest circumference /_/_/_/_/ (4:8-460)
mms (NR=999) /_/_/_/_/ (4:1-463)
inches*10 (NR=999)

63. Length /_/_/_/_/ (4:4-466)
mms (NR=999) /_/_/_/_/ (4:7-469)
inches*10 (NR=999)

64. Gestational age in weeks /_/_/_/ (4:0-471)
(NR=99)

65. Gestational age categories: /_/_/ (4:2)
1=Term
2=Preterm
3=Post term
9=NR

66. Gestational age determination by		
1=Dates	/_/	(473)
2=Ultrasound		
3=Neonatal exam		
9=NR		
67. Apgar score - 1 min (NR=99, NA=88)	/_/_/	(474-475)
5 min (NR=99, NA=88)	/_/_/	(476-477)
68. Did the baby need resuscitation at birth?		
1=No	/_/	(478)
2=Yes intubation/ambouabag		
8=NA		
9=NR		
69. Religion	/_/	(479)
1=Catholic		
2=Protestant		
3=Other Christian		
4=Jewish		
5=Other		
6=None		
9=NR		
Blank space	/_/	(480)
70. Blood Group ABO (baby):		
1=A	/_/	(481)
2=B		
3=AB		
4=O		
9=NR		
71. Rh (baby):		
1=Rh Positive	/_/	(482)
2=Rh Negative		
9=NR		
72. If child is a male, was he circumcised?		
1=Yes	/_/	(483)
2=No		
8=NA		
9=NR		
73. Type of feeding		
1=Breast	/_/	(484)
2=Bottle		
3=Both		
4=Other		
8=NA		
Check list for neonatal conditions	1=Yes 2=No 3= suspected 8=NA	
74. Prematurity	/_/	(485)
75. Hyaline membrane disease/ Respiratory distress syndrome	/_/	(486)

76. Hemolytic disease of the newborn			
ABO	/_/_		(487)
Rh	/_/_		(488)
77. Infection			
Sepsis	/_/_		(489)
Meningitis	/_/_		(490)
Other	/_/_		(491)
78. Birth asphyxia	/_/_		(492)
79. Neonatal seizures	/_/_		(493)
80. Neonatal jaundice	/_/_		(494)
81. If yes, record highest bilirubin level in the chart (Mg%, NR=999, NA=888)	/_/_/_/_		(495-497)
82. Date of test		Month	/_/_/_
		Day	/_/_/_
		Year	/_/_/_
			(498-499)
			(500-501)
			(502-503)
<u>Diagnostic Procedures</u> 1=Yes, 2=No, 8=NA			
83. X-rays	/_/_		(504)
84. Ultrasound	/_/_		(505)
85. CT Scan	/_/_		(506)
86. Echocardiogram	/_/_		(507)
87. EKG	/_/_		(508)
88. Cytogenetic Studies (karyotype)	/_/_		(509)
89. Results 1=Normal, 2=Abnormal, 8=NA, 9=NR	/_/_		(510)
Record: _____			
90. Torch Studies	/_/_		(511)
91. Results 1=Normal, 2=Abnormal, 8=NA, 9=NR	/_/_		(512)
Record: _____			
92. Lumbar puncture	/_/_		(513)

93. Pathology

1=Yes

/_/_

(514)

2=No

8=NA

Findings

ICD 9 Codes

/_/_/_/_/_

(515-518)

/_/_/_/_/_

(519-522)

/_/_/_/_/_

(523-526)

/_/_/_/_/_

(527-530)

Blank space

/_/_

(531)

94. Surgical procedures

1=Yes

/_/_

(532)

2=No

8=NA

95. Title of procedure(s)

ICD 9 CM

/_/_/_/_/_

(533-536)

/_/_/_/_/_

(537-540)

/_/_/_/_/_

(541-544)

/_/_/_/_/_

(545-548)

96. Autopsy

1=Yes, reviewed

/_/_

(549)

2=Yes, pending

3=No

8=NA

9=NR

97. Anatomic diagnoses

	ICD 9 Codes	
_____	/_/_/_/_/	(550-553)
_____	/_/_/_/_/	(554-557)
_____	/_/_/_/_/	(558-561)
_____	/_/_/_/_/	(562-565)
_____	/_/_/_/_/	(566-569)
_____	/_/_/_/_/	(570-573)
_____	/_/_/_/_/	(574-577)
_____	/_/_/_/_/	(578-581)
_____	/_/_/_/_/	(582-585)
_____	/_/_/_/_/	(586-589)

98. Status at discharge

- 1=alive
- 2=dead
- 9=NR

/_/_/ (590)

99. Date of death

Month
Day
Year

/_/_/ (591-592)
/_/_/ (593-594)
/_/_/ (595-596)

100. Blank spaces

/_/_/_/_/ (597-600)

101. List all final diagnoses
 recorded in the chart
 (S=1, confirmed; S=2, suspected)

	ICD 9	S
_____	/_/_/_/_/	/_/_/ (601-605)
_____	/_/_/_/_/	/_/_/ (606-610)
_____	/_/_/_/_/	/_/_/ (611-615)
_____	/_/_/_/_/	/_/_/ (616-620)
_____	/_/_/_/_/	/_/_/ (621-625)
_____	/_/_/_/_/	/_/_/ (626-630)
_____	/_/_/_/_/	/_/_/ (631-635)
_____	/_/_/_/_/	/_/_/ (636-640)
_____	/_/_/_/_/	/_/_/ (641-645)
_____	/_/_/_/_/	/_/_/ (646-650)

102. List all congenital malformations not
 recorded in the final diagnoses list
 (S=1, confirmed; S=2, suspected;
 S=3, nurses note only)

	ICD 9	S
_____	/_/_/_/_/	/_/_/ (651-655)
_____	/_/_/_/_/	/_/_/ (656-660)
_____	/_/_/_/_/	/_/_/ (661-665)
_____	/_/_/_/_/	/_/_/ (666-670)
_____	/_/_/_/_/	/_/_/ (671-675)
_____	/_/_/_/_/	/_/_/ (676-680)
_____	/_/_/_/_/	/_/_/ (681-685)
_____	/_/_/_/_/	/_/_/ (686-690)
_____	/_/_/_/_/	/_/_/ (691-695)
_____	/_/_/_/_/	/_/_/ (696-700)

103. List medical conditions and complications
not recorded in the final diagnoses list
(S=1, confirmed; S=2, suspected;
S=3, nurses note only)

	ICD 9	S	
_____	/ / / / /	/ /	(701-705)
_____	/ / / / /	/ /	(705-710)
_____	/ / / / /	/ /	(711-715)
_____	/ / / / /	/ /	(715-720)
_____	/ / / / /	/ /	(721-725)
_____	/ / / / /	/ /	(725-730)
_____	/ / / / /	/ /	(731-735)
_____	/ / / / /	/ /	(735-740)
_____	/ / / / /	/ /	(741-745)
_____	/ / / / /	/ /	(745-750)

APPENDIX F

Quality Control of Hospital Records Abstraction

