SERIAL NUMBER (7 DIGITS) CKL PERSON NO.

NDNS NHS (A)

National Diet and Nutrition Survey (NDNS)

NHS Central Register and Cancer Register

(Adults 16+)

- The NHS Central Register lists all the people in the country and their National Health Service (NHS) number.
- We would like to ask for your consent for us to send your name, address and date of birth to the National Health Service Central Register. A marker will be put against your name to show that you took part in the National Diet and Nutrition Survey.
- If a person who took part in the National Diet and Nutrition Survey gets cancer, or dies, the type of cancer or cause of death will be linked with their answers to the survey. By linking this information the research is more useful as we can look at how people's lifestyle can have an impact on their future health.
- This information will be confidential and used for research purposes only.
- By signing this form you are only giving permission for the linking of this information to routine administrative data and nothing else. We will not be able to obtain any other details from your medical records.
- You can cancel this permission at any time in the future by writing to us at the following address:
  National Centre for Social Research, 35 Northampton Square, London EC1V 0AX

Your consent

I, (name) _____ consent to the NDNS team passing my name, address and date of birth to the ***National Health Service Central Register***. I understand that information held by ***the NHS Central Register*** may be used to follow up my health status.

Signed _____ *Date* _____

I understand that these details will be used for research purposes only.

NDNS(N)

National Diet and Nutrition Survey (NDNS)

CONSENT BOOKLET: PERSONAL COPY

Serial Number: | | | | | | | | | |

First Name:

CONSENT FORM FOR NDNS CF (A1)

ADULT AGED 16+

Respondent's name_____(BLOCK LETTERS)

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.

I hereby consent to the following aspects of the study:

BLOOD PRESSURE (TO GP) CONSENT:

Please initial box if consent given

☐ The survey team sending my blood pressure measurement to my GP.

BMI (TO GP) CONSENT:

Please initial box if consent given

☐ The survey team sending my body mass index (BMI) measurements to my GP.

24 HOUR URINE CONSENTS:

Please initial box if consent given

☐ Taking PABA tablets to support the 24-hour urine collection.

☐ Laboratory analysis of my 24-hour urine collection, to help assess my diet.

☐ Storage of any remaining urine for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my urine at any time, without giving any reason, by asking the investigators in writing for my urine to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

Signature: ……Date ……..

CONSENT FORM FOR NDNS CF (A2)

ADULT AGED 16+

Respondent's name_____(BLOCK LETTERS)

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.

I hereby consent to the following aspects of the study:

BLOOD SAMPLING CONSENTS:

Please initial box if consent given

☐ Having a blood sample for tests related to nutrition and health. This blood sample will not be used for HIV or genetic testing.

☐ I would like / would not like *(delete as appropriate)* to receive a written report of my clinically relevant blood results*****.

☐ The NDNS team sending my potentially clinically relevant blood results to my GP*.

☐ Storage of any remaining blood for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my blood at any time, without giving any reason, by asking the investigators in writing for my blood to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

*Please note that if you do not want to receive a report of your blood results **and** do not want results to be passed on to your GP we need you to sign a disclaimer (page 6).

Signature: ……Date ……..

CONSENT FORM FOR NDNS CF (C1)

CHILDREN AGED 4 TO 15 YEARS

Parent/Guardian Section

I agree for my child to participate in the above named survey and in doing so acknowledge that:

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my child's identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.

I hereby agree for my child to participate in the following aspects of the survey:

BLOOD PRESSURE (TO GP) CONSENT:

Please initial box if consent given

☐ The survey team sending his/her blood pressure measurement to his/her GP.

24 HOUR URINE CONSENTS:

Please initial box if consent given

☐ Taking PABA tablets to support the 24-hour urine collection.

☐ Laboratory analysis of his/her 24-hour urine collection, to help assess his/her diet.

☐ Storage of any remaining urine for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my child's urine at any time, without giving any reason, by asking the investigators in writing for his/her urine to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

Respondent's (Child's) Name:……..

Parent/Guardian Name: ……

Parent/Guardian signature: ……Date …….

Child assent

I agree to take part in the NDNS survey. I understand the measurements that will be made.

Respondent (Child) signature: ……Date……

CONSENT FORM FOR NDNS CF (C2)

CHILDREN AGED 4 TO 15 YEARS

Parent/Guardian Section

I agree for my child to participate in the above named survey and in doing so acknowledge that:

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my child's identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.
- I have been given written information about the Ametop gel and the nurse has explained the purpose and use of Ametop gel to me.

I hereby agree for my child to participate in the following aspects of the survey:

BLOOD SAMPLING CONSENTS:

Please initial box if consent given

☐ Blood sample for tests related to nutrition and health. This blood sample will not be used for HIV or genetic testing. Please tick the appropriate box:

☐ with Ametop gel ☐ without Ametop gel

☐ I would like / would not like *(delete as appropriate)* to receive a written report of my child's clinically relevant blood results*.

☐ The NDNS team sending potentially clinically relevant blood results to his/her GP*.

☐ Storage of any remaining blood for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my child's blood at any time, without giving any reason, by asking the investigators in writing for his/her blood to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

*Please note that if you do not want to receive a report of your child's blood results **and** do not want results to be passed on to his/her GP we need you to sign a disclaimer (page 6).

Respondent's (Child's) Name:……..

Parent/Guardian Name: ……

Parent/Guardian signature: ……Date …….

Child assent

I agree to take part in the NDNS survey. I understand the measurements that will be made.

Respondent (Child) signature: ……Date……

CHILDREN AGED 1.5 TO 3 YEARS

Parent/Guardian Section

I agree for my child to participate in the above named survey and in doing so acknowledge that:

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my child's identity.
- I understand that I may withdraw my consent to any or all of the study elements at any time without needing to give a reason.
- I have been given written information about the Ametop gel and the nurse has explained the purpose and use of Ametop gel to me.

I hereby agree for my child to participate in the following aspects of the study:

BLOOD SAMPLING CONSENTS:

Please initial box if consent given

☐ Blood sample for tests related to nutrition and health. This blood sample will not be used for HIV or genetic testing. Please tick the appropriate box:

☐ with Ametop gel ☐ without Ametop gel

☐ I would like / would not like *(delete as appropriate)* to receive a written report of my child's clinically relevant blood results*.

☐ The NDNS team sending potentially clinically relevant blood results to his/her GP*.

☐ Storage of any remaining blood for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my child's blood at any time, without giving any reason, by asking the investigators in writing for his/her blood to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

*Please note that if you do not want to receive a report of his/her blood results **and** do not want results to be passed on to his/her GP we need you to sign a disclaimer (page 6).

Respondent's (Child's) Name:……..

Parent/Guardian Name: ……

Parent/Guardian signature: ……Date …….

NDNS DISCLAIMER

Date:…….

Name:……. (Block letters)

Respondent's name: ……. (Block letters)
(if different from above)

This is to clarify that against the advice of the NDNS survey team I:

Please initial boxes

☐ Do not want to receive my / my child's *(delete as appropriate)* clinically relevant examination results

☐ Do not want my / my child's *(delete as appropriate)* clinically relevant examination results being sent to my / his/her *(delete as appropriate)* GP

I do understand that if there are findings outside the normal range this will not be brought to the attention of any health care provider.

By doing so, I assume all responsibility for my act.

Signed:……

Nurse:…….

National Diet and Nutrition Survey – Consent Booklet: Office Copy

Please use capital letters and write in ink

ADDRESS

INDIVIDUAL SERIAL NUMBER:
Affix label **NCON** here for this person:

*STICK **NCON** **(1)** LABEL HERE*

1. Nurse number: | | | | | | |

2. Date schedule completed (all visits complete): DAY | | MONTH | | YEAR | | | | |

3. Full name (of person tested) _____

Name by which GP knows person (if different) _____

4. Sex — Male 1; Female 2

5. Date of birth: DAY | | MONTH | | YEAR | | | | |

6. Full name of parent/guardian (*if person under 16*) _____

7.

GP NAME AND ADDRESS

Dr: .....

Practice Name: .....

Address: .....

.....

Town: .....

County: .....

Postcode: .....

Telephone no: .....

8.

SUMMARY OF CONSENTS - RING CODE FOR EACH ITEM	**YES**	**NO**
a) Blood pressure to **GP**	01	02
b) Body Mass Index (BMI) to **GP**	03	04
c) Take PABA tablet	05	06
d) Lab analysis of Urine	07	08
e) Urine sample for **storage**	09	10
f) Sample of blood to be taken	11	12
g) Blood sample result to **GP**	13	14
h) Blood sample for **storage**	15	16
i) Blood sample result to **respondent**	17	18

BLOOD SAMPLE LABORATORY REFERENCE LIST

The tables below show which blood samples should be taken (in priority order) and need to be sent to each lab for each age group:

RESPONDENTS AGED 16+

Priority	Blood Tube	Colour	Label Reference	Laboratory	Despatch note
1	EDTA 1	RED	EN1	Addenbrookes	DESP ADDX
2	SERUM 1	BROWN	SEN1	Addenbrookes	DESP ADDX
3	SERUM 2	WHITE	SEN2	Field Lab	DESP FL2.1
4	LI HEP 1	ORANGE	LHN1	Field Lab	DESP FL2.1
5	LI HEP 2	ORANGE	LHN2	Field Lab	DESP FL2.1
6	FLUORIDE	YELLOW	FN1	Field Lab	DESP FL2.1
7	LI HEP 3	ORANGE	LHN3	Field Lab	DESP FL2.1
8	EDTA 2	RED	EN2	Field Lab	DESP FL2.1

RESPONDENTS AGED 7-15

Priority	Blood Tube	Colour	Label Reference	Laboratory	Despatch note
1	EDTA 1	RED	EN1	Addenbrookes	DESP ADDX
2	LI HEP 1	ORANGE	LHN1	Field Lab	DESP FL2.2
3	SERUM 1	BROWN	SEN1	Addenbrookes	DESP ADDX
4	SERUM 2	WHITE	SEN2	Field Lab	DESP FL2.2
5	LI HEP 2	ORANGE	LHN2	Field Lab	DESP FL2.2
6	FLUORIDE	YELLOW	FN1	Field Lab	DESP FL2.2

RESPONDENTS AGED 18 mths – 6 yrs

Priority	Blood Tube	Colour	Label Reference	Laboratory	Despatch note
1	EDTA 1	RED	EN1	Addenbrookes	DESP ADDX
2	LI HEP 1	ORANGE	LHN1	Field Lab	DESP FL2.3
3	SERUM 1	BROWN	SEN1	Addenbrookes	DESP ADDX
4	SERUM 2	WHITE	SEN2	Field Lab	DESP FL2.3

CONSENT FORM FOR NDNS CF (A1)

ADULT AGED 16+

Respondent's name_____(BLOCK LETTERS)

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.

I hereby consent to the following aspects of the study:

BLOOD PRESSURE (TO GP) CONSENT:

Please initial box if consent given

☐ The survey team sending my blood pressure measurement to my GP.

BMI (TO GP) CONSENT:

Please initial box if consent given

☐ The survey team sending my body mass index (BMI) measurements to my GP.

24 HOUR URINE CONSENTS:

Please initial box if consent given

☐ Taking PABA tablets to support the 24-hour urine collection.

☐ Laboratory analysis of my 24-hour urine collection, to help assess my diet.

☐ Storage of any remaining urine for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my urine at any time, without giving any reason, by asking the investigators in writing for my urine to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

Signature: ……Date ……..

CONSENT FORM FOR NDNS CF (A2)

ADULT AGED 16+

Respondent's name_____(BLOCK LETTERS)

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.

I hereby consent to the following aspects of the study:

BLOOD SAMPLING CONSENTS:

Please initial box if consent given

☐ Having a blood sample for tests related to nutrition and health. This blood sample will not be used for HIV or genetic testing.

☐ I would like / would not like *(delete as appropriate)* to receive a written report of my clinically relevant blood results*****.

☐ The NDNS team sending my potentially clinically relevant blood results to my GP*.

☐ Storage of any remaining blood for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my blood at any time, without giving any reason, by asking the investigators in writing for my blood to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

*Please note that if you do not want to receive a report of your blood results **and** do not want results to be passed on to your GP we need you to sign a disclaimer (page 8).

Signature: ……Date ……..

CONSENT FORM FOR NDNS CF (C1)

CHILDREN AGED 4 TO 15 YEARS

Parent/Guardian Section

I agree for my child to participate in the above named survey and in doing so acknowledge that:

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my child's identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.

I hereby agree for my child to participate in the following aspects of the survey:

BLOOD PRESSURE (TO GP) CONSENT:

Please initial box if consent given

☐ The survey team sending his/her blood pressure measurement to his/her GP.

24 HOUR URINE CONSENTS:

Please initial box if consent given

☐ Taking PABA tablets to support the 24-hour urine collection.

☐ Laboratory analysis of his/her 24-hour urine collection, to help assess his/her diet.

☐ Storage of any remaining urine for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my child's urine at any time, without giving any reason, by asking the investigators in writing for his/her urine to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

Respondent's (Child's) Name:……..

Parent/Guardian Name: ……

Parent/Guardian signature: ……Date …….

Child assent

I agree to take part in the NDNS survey. I understand the measurements that will be made.

Respondent (Child) signature: ……Date……

CONSENT FORM FOR NDNS CF (C2)

CHILDREN AGED 4 TO 15 YEARS

Parent/Guardian Section

I agree for my child to participate in the above named survey and in doing so acknowledge that:

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my child's identity.
- I understand that I may withdraw my consent to any or all of the survey elements at any time without needing to give a reason.
- I have been given written information about the Ametop gel and the nurse has explained the purpose and use of Ametop gel to me.

I hereby agree for my child to participate in the following aspects of the survey:

BLOOD SAMPLING CONSENTS:

Please initial box if consent given

☐ Blood sample for tests related to nutrition and health. This blood sample will not be used for HIV or genetic testing. Please tick the appropriate box:

☐ with Ametop gel ☐ without Ametop gel

☐ I would like / would not like *(delete as appropriate)* to receive a written report of my child's clinically relevant blood results*.

☐ The NDNS team sending potentially clinically relevant blood results to his/her GP*.

☐ Storage of any remaining blood for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my child's blood at any time, without giving any reason, by asking the investigators in writing for his/her blood to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

*Please note that if you do not want to receive a report of your child's blood results **and** do not want results to be passed on to his/her GP we need you to sign a disclaimer (page 8).

Respondent's (Child's) Name:……..

Parent/Guardian Name: ……

Parent/Guardian signature: ……Date …….

Child assent

I agree to take part in the NDNS survey. I understand the measurements that will be made.

Respondent (Child) signature: ……Date……

CHILDREN AGED 1.5 TO 3 YEARS

Parent/Guardian Section

I agree for my child to participate in the above named survey and in doing so acknowledge that:

- I have received the information leaflets (Interviewer and Nurse versions) which explain the nature and purpose of the study. I have read and understood these leaflets.
- I am satisfied with any enquiries I have made regarding the study.
- I have been informed that the results will be kept confidential and presented in a way that protects my child's identity.
- I understand that I may withdraw my consent to any or all of the study elements at any time without needing to give a reason.
- I have been given written information about the Ametop gel and the nurse has explained the purpose and use of Ametop gel to me.

I hereby agree for my child to participate in the following aspects of the study:

BLOOD SAMPLING CONSENTS:

Please initial box if consent given

☐ Blood sample for tests related to nutrition and health. This blood sample will not be used for HIV or genetic testing. Please tick the appropriate box:

☐ with Ametop gel ☐ without Ametop gel

☐ I would like / would not like *(delete as appropriate)* to receive a written report of my child's clinically relevant blood results*.

☐ The NDNS team sending potentially clinically relevant blood results to his/her GP*.

☐ Storage of any remaining blood for tests in the future relating to nutrition and health, provided that the tests are approved by an NHS ethics committee. I understand that I can withdraw my consent to store my child's blood at any time, without giving any reason, by asking the investigators in writing for his/her blood to be removed from storage and destroyed. I understand that my data is being used in anonymised form only.

*Please note that if you do not want to receive a report of his/her blood results **and** do not want results to be passed on to his/her GP we need you to sign a disclaimer (page 8).

Respondent's (Child's) Name:……..

Parent/Guardian Name: ……

Parent/Guardian signature: ……Date …….

NDNS DISCLAIMER

Date:…….

Name:……. (Block letters)

Respondent's name: ……. (Block letters)
(if different from above)

This is to clarify that against the advice of the NDNS survey team I:

Please initial boxes

☐ Do not want to receive my / my child's *(delete as appropriate)* clinically relevant examination results

☐ Do not want my / my child's *(delete as appropriate)* clinically relevant examination results being sent to my / his/her *(delete as appropriate)* GP

I do understand that if there are findings outside the normal range this will not be brought to the attention of any health care provider.

By doing so, I assume all responsibility for my act.

Signed:……

Nurse:…….

RESEARCH ANALYSIS REQUEST (v5) 952

Nurses - fill in sections in bold only

Volunteer Details

Surname: HNR (use top 9 digit number of label)

First name: P952

Meditech COHD: SEN1 (use 7 digit no. at bottom of SEN1 label)
EN1 (use 7 digit no. at bottom of EN1 label)

DOB / / dd/mm/yyyy

Male 1
Female 2
circle as appropriate

Affix serial number label

Adx1(11)
or
Adx2 (12)
or
Adx3 (13)

Study Details

Consultant JMHNR

Location NDNS

Title NDNS

Contact Katie Dearnley
01223 426356

Contact OOH Dr Jennifer Mindell
020 7679 1269

Sample Details

Date / / dd/mm/yyyy
Time : 24hr clock

Volunteer Fasted **Yes** 1 **No** 2 circle as appropriate

Sample Tube			Tests	Lab order	Lab barcode	Lab processing
Serum SEN1 brown	**Full**	circle as appropriate	Creatinine CRP Lipid Profile TSH Free T4 Free T3	CP952	BIOCHEM BARCODE EDTA sample must be labelled with both biochem&haem barcodes	Automation rack
	Partial					
EDTA EN1 red	**Full**	circle as appropriate	HbA1c Red Cell Folate			Pass to Endo Staff for division of EDTA - instructions below
	Partial		FBC	HA952	HAEM BARCODE	

EDTA separation

Depending on sample volume split the whole blood in the following priority

FBC

Minimum volume required is 1ml – there will be three options:

- Volume less than 1ml (e.g. partial sample) proceed to folate aliquoting and add Meditech comment HAZINS against the haem barcode
- Volume very close to 1ml send primary tube to Haem with the pink duplicate request form, add Meditech comment CCOM and free text against the biochem barcode
- Volume more than ~1.7ml proceed to aliquoting whole blood for folate then primary tube to Haem with the pink duplicate request form

Folate

Take 2x 2ml tubes of ascorbic acid from the bottom half of the -80°C Protect freezer and defrost. Each contains 1ml ascorbic acid – check it has not expired.
Print patient biochem barcodes (screen 66)
Label 2x defrosted 2ml ascorbic acid tubes with HNR barcode labels (FOL1 & FOL2) supplied in the delivery pack, then label with patient biochem barcodes. DO NOT COVER HNR BARCODE WITH BIOCHEM BARCODE
Invert the primary EDTA tube a few times to re-suspend the contents
Transfer exactly 100µl from primary EDTA tube into each tube containing 1ml ascorbic acid and invert to mix
Store in the -80°C Protect freezer
If there is sufficient volume proceed to aliquoting whole blood for A1c
If there is insufficient volume left for A1c add a Meditech comment CCOM and free text against the biochem barcode

HbA1c

Label 1x 2ml secondary tube with patient biochem barcode and write A1c
Invert the primary EDTA tube a few times to re-suspend the contents
Transfer 0.5ml from primary EDTA tube into secondary tube
Place secondary tube in A1c skip in office

NATIONAL DIET AND NUTRITION SURVEY

BLOOD SAMPLE DESPATCH NOTE FIELD LAB 1 (16+) DESP FL 2.1

SECTION 1: NURSE complete <u>all</u> sections CLEARLY & LEGIBLY. Enclose with samples to Field Lab

1. Respondent Details

Please affix serial number label here

label FL2 (14)

2. Record respondents sex:

Male:	1
Female:	2

3. Was the respondent:

Fasted	1
Non-fasted	2

4. Date sample taken: Day | Month | Year

5. Time sample taken: 24 hr clock :

6. Time sample delivered to lab: 24 hr clock :

7. Nurse Number

SECTION 2: TO BE COMPLETED BY THE FIELD LABORATORY

A. Date sample arrived: Day | Month | Year

B. Time of arrival 24 hr clock :

C. Complete table below:

Samples expected:	Sample received?		Volume receiv'd?	Are tubes damaged?	
	Yes	**No**	**mls**	**Yes**	**No**
EDTA (Red Top) 2.6ml (EN2)					
LiHep 1 (Orange Top) 7.5ml (LHN1)					
LiHep 2 (Orange Top) 7.5ml (LHN2)					
LiHep 3 (Orange Top) 4.5ml (LHN3)					
Plain Serum (White top) 4.5ml (SEN2)					
Fluoride (Yellow top) 1.2ml (FN1)					

Lab technician/analyst:

Please transfer 1300µl whole blood from the well mixed LH N3 tube to the blue capped storage tube (label: LH WB) before starting centrifugation. Place aliquot on ice if not transferred to freezer immediately.

D. Centrifuge tubes as described in the protocol and then complete the following table:

Sample	Time tube centrifuged (24hr clock)	Is the sample abnormal?		If abnormal, code reason *(enter code from list)*
		Yes	**No**	
EN2	:			
LHN1	:			
LHN2	:			
LHN3	:			
SEN2	:			
FN1	:			

Code frame for abnormal samples:

1 = Haemolysed
2 = Turbid
3 = Lipemic
4 = Frozen
5 = Clot Present (EDTA/LiHep only)
6 = Entirely clotted (EDTA/LiHep only)
7 = Not Clotted (plain serum only)
8 = Other (please describe overleaf)

Please write the sample ID no. in the box opposite before faxing this form. The sample ID is the 9 digit number at the top of the bar coded label overleaf.

Sample ID:

If other abnormality, please describe here:

E. Please complete table:

Sample	Required Vol (μl)	Actual Vol(μl)	Time of aliquoting	Time of entry into freezer
LH1	800			
LH2	800			
LHVC	300			
LH3	800			
LH4	200			
LH5	400			
LH6	400			
LH7	500			
LH8*	1500			
LH9*	600 - 1200			
E1	1000			
SE1	600			
SE2*	600			
SE3*	600			
F1	500			
LHWB (from LHN3)	1300			
LHN1 washed RBC's	N/A	N/A	N/A	
LHN2 washed RBC's	N/A	N/A	N/A	
LHN3 washed RBC's	N/A	N/A	N/A	

*Please use the remaining plasma to fill LH8 and LH9. Use the remaining serum to fill SE2 and SE3. It is anticipated that there **will not always** be sufficient plasma/serum to fill to the desirable volume. If plasma from either of the LiHep tubes is haemolysed use the clear plasma to fill priority tubes, and the haemolysed plasma to fill the remaining tubes. But always use LiHep plasma from LHN1 or LHN2 (trace metal monovettes) to fill LH5 and LH6. If you have to use LHN3 plasma for LH5 and LH6 then please make a note in the table above.

F. Record temperature samples stored at: _____ **^{o}C**

G. Sign form - Analyst/Technician sign form:_____ **(signature)**

_____ **(Print name)**

This record must **be faxed to HNR** on the day of sample processing:
Fax No.: **01223 437546.** The original should be returned to HNR with the samples and spare labels via courier at the pre-arranged date.

For queries, please contact Katie Dearnley (01223 437543) or Dr Sonja Nicholson (01223 437574) at MRC Human Nutrition Research, 120 Fulbourn Road, Cambridge, CB1 9NL

NATIONAL DIET AND NUTRITION SURVEY

BLOOD SAMPLE DESPATCH NOTE – FIELD LAB 1 (aged 7-15) DESP FL2.2

SECTION 1: NURSE complete <u>all</u> sections CLEARLY & LEGIBLY. Enclose with samples to Field Lab

1. Respondent Details

Please affix serial number label here

Label FL2(14)

2. Record respondents sex:

Male:	1
Female:	2

3. Was the respondent:

Fasted	1
Non-fasted	2

4. Date sample taken:

Day		Month		Year			

5. Time sample taken: (24 hr clock) :

6. Time sample delivered to lab: (24 hr clock) :

7. Nurse Number

SECTION 2: TO BE COMPLETED BY THE FIELD LABORATORY

A. Date sample arrived:

Day		Month		Year			

B. Time of arrival (24 hr clock) :

C. Complete table below:

Samples expected:	Sample received?		Volume receiv'd?	Are tubes damaged?	
	Yes	**No**	**mls**	**Yes**	**No**
LiHep 1 (Orange Top) 7.5ml (LHN1)					
LiHep 2 (Orange Top) 2.7ml (LHN2)					
Plain Serum (White top) 4.5ml (SEN2)					
Fluoride (Yellow top) 1.2ml (FN1)					

D. Centrifuge tubes as described in the protocol and then complete the following table:

Sample	Time tube centrifuged (24hr clock)	Is the sample abnormal?		If abnormal, code reason *(enter code from list)*
		Yes	**No**	
LHN1	:			
LHN2	:			
SEN2	:			
FN1	:			

Code frame for abnormal samples:

1 = Haemolysed
2 = Turbid
3 = Lipemic
4 = Frozen
5 = Clot Present (EDTA/LiHep only)
6 = Entirely clotted (EDTA/LiHep only)
7 = Not Clotted (plain serum only)
8 = Other (please describe overleaf)

Please write the sample ID no. in the box opposite before faxing this form. The sample ID is the 9 digit number at the top of the bar coded label overleaf.

Sample ID:

If other abnormality, please describe here:

E. Please complete table:

Sample	Required Vol (μl)	Actual Vol(μl)	Time of aliquoting	Time of entry into freezer
LH1	600			
LH2	800			
LHVC	300			
LH3	800			
LH4	300			
LH5	200			
LH6	500			
LH7	300			
SE1	600			
SE2	600			
SE3	600			
F1	500			
LHN1 washed RBCs	N/A	N/A	N/A	
LHN2 washed RBCs	N/A	N/A	N/A	

If plasma from either of the LiHep tubes is haemolysed use the clear plasma to fill priority tubes, and the haemolysed plasma to fill the remaining tubes. But always use LiHep plasma from LHN1 (trace metal monovette) to fill LH4. If you have to use LHN2 plasma for LH4 then please make a note in the table above.

F. Record temperature samples stored at: _____ **^{o}C**

G. Sign form - Analyst/Technician sign form:_____ **(signature)**

_____ **(Print name)**

This record must **be faxed to HNR** on the day of sample processing:
Fax No.: **01223 437546.** The original should be returned to HNR with the samples and spare labels via courier at the pre-arranged date.

For queries, please contact Katie Dearnley (01223 437543) or Dr Sonja Nicholson (01223 437574) at MRC Human Nutrition Research, 120 Fulbourn Road, Cambridge, CB1 9NL

NATIONAL DIET AND NUTRITION SURVEY

BLOOD SAMPLE DESPATCH NOTE – FIELD LAB 1 (18mths – 6yrs) **DESP FL2.3**

SECTION 1: NURSE complete <u>all</u> sections CLEARLY & LEGIBLY. Enclose with samples to Field Lab

1. Respondent Details

Please affix serial number label here

Label FL2(14)

2. Record respondents sex:

Male:	1
Female:	2

3. Was the respondent:

Fasted	1
Non-fasted	2

4. Date sample taken: Day | Month | Year

5. Time sample taken: 24 hr clock : :

6. Time sample delivered to lab: 24 hr clock : :

7. Nurse Number

SECTION 2: TO BE COMPLETED BY THE FIELD LABORATORY

A. Date sample arrived: Day | Month | Year

B. Time of arrival 24 hr clock : :

C. Complete table below:

Samples expected:	Sample received?		Volume receiv'd?	Are tubes damaged?	
	Yes	**No**	**mls**	**Yes**	**No**
LiHep (Orange Top) 4.5ml (LHN1)					
Plain Serum (White top) 2.7ml (SEN2)					

D. Centrifuge tubes as described in the protocol and then complete the following table:

Sample	Time tube centrifuged (24hr clock)	Is the sample abnormal?		If abnormal, code reason *(enter code from list)*
		Yes	**No**	
LHN1	:			
SEN2	:			

Code frame for abnormal samples:

1 = Haemolysed
2 = Turbid
3 = Lipemic
4 = Frozen
5 = Clot Present (EDTA/LiHep only)
6 = Entirely clotted (EDTA/LiHep only)
7 = Not Clotted (plain serum only)
8 = Other (please describe overleaf)

Please write the sample ID no. in the box opposite before faxing this form.
The sample ID is the 9 digit number at the top of the bar coded label overleaf.

Sample ID:

If other abnormality, please describe here:

E. Please complete table:

Sample	**Required Vol (μl)**	**Actual Vol(μl)**	**Time of aliquoting**	**Time of entry into freezer**
LH1	400			
LH2	600			
LHVC	300			
LH3	500			
SE1	600			
SE2	400			
LHN1 washed RBCs	N/A	N/A	N/A	

F. Record temperature samples stored at: _____ **^{o}C**

G. Sign form - Analyst/Technician sign form:_____ **(signature)**

_____ **(Print name)**

This record must **be faxed to HNR** on the day of sample processing:
Fax No.: **01223 437546.** The original should be returned to HNR with the samples and spare labels via courier at the pre-arranged date.

For queries, please contact Katie Dearnley (01223 437543) or Dr Sonja Nicholson (01223 437574) at MRC Human Nutrition Research, 120 Fulbourn Road, Cambridge, CB1 9NL

24 HOUR URINE SAMPLE DESPATCH NOTE DESP URINE

To be completed by the nurse

Nurse Name | | ***Nurse Number*** | | | | | | |

1. Respondent details

Please affix serial number label here

Label UDESP(36)

Please complete one record for each respondent.

Q1 Did the respondent consent to taking PABA tablets?

Yes ☐
No ☐

Q2 Did the respondent keep the PABA tablet packaging?

Yes ☐ Send the packaging, including any remaining tablets, to HNR in the postal pack provided

No ☐

Q3 Did the respondent consent to the storage of any remaining urine?

Yes ☐
No ☐

Q4 Was there any urine inside the 2L bottle?

Yes ☐ Weigh BOTH the 2L and 5L bottles separately BEFORE mixing together (if possible) to sub sample the urine. Record 5 litre weights at **Q5** and 2 litre weights at **Q6**.

No ☐ Weigh the 5L bottle only. Record weights below (**Q5**).

Q5 **Type of container:** ☐ **5.0L** jerry can

- Weigh the urine a **first time**, on the digital scales provided, and record the weight in **kilograms** of the 5L bottle containing the urine:

		kg

- Weigh the urine a **second time** and record the weight in **kilograms** of the 5L bottle containing the urine:

		Kg

- If the first and second weights differ by more than 0.02kg weigh the urine a **third time** and record the weight in **kilograms** of the 5L bottle containing the urine:

				kg

If no urine in 2L bottle: mix the urine and take **4 sub-samples** and discard the remaining urine and equipment as per instructions provided. **If any urine in 2L bottle: go to Q6.**

Q6. **Type of container:** ☐ **2.0L** jerry can

- Weigh the urine a **first time**, on the digital scales provided, and record the weight in **kilograms** of the 2L bottle containing the urine:

				kg

- Weigh the urine a **second time** and record the weight in **kilograms** of the 2L bottle containing the urine:

				kg

- If the first and second weights differ by more than 0.02kg weigh the urine a **third time** and record the weight in **kilograms** of the 2L bottle containing the urine:

				kg

Q7. Can all urine in the 2L bottle be transferred into the 5L bottle?

Yes	☐	Go to Q8
No	☐	Go to Q9

Q8. Weigh first, then transfer urine from 2L bottle to 5L bottle. Mix urine before sub-sampling from 5L bottle **only**: mix the urine and take **4 sub-samples** and discard the remaining urine and equipment as per instructions provided.

Q9. If urine collected in 2L bottle will not fit in 5L bottle, do not transfer. Note the weight of the 2L bottle above but **only** sub-sample from 5L bottle: mix the urine and take **4 sub-samples** and discard the remaining urine and equipment as per instructions provided.

Please use the packaging provided to send the following items to HNR:

- **one copy of the respondent 24-hour urine collection sheet**
- **the completed urine volume and dispatch sheet**
- **and the urine sub-samples**

Please post the packet of samples as soon as possible in a post-box; check for same day collection.

DESPATCH NOTE FOR ALL SAMPLES **DESP OFFICE**

(OFFICE COPY)

1. Respondent Details

Please affix serial number label here

Label OFFDESP (2)

2. Age group:

Circle one code only

Samples obtained: *(tick all that apply)*

16+	**1**	EDTA 1 ☐	EDTA 2 ☐	Serum 1 ☐	Serum 2 ☐	Li Hep1 ☐	Li Hep2 ☐	Li Hep3 ☐	Fluoride ☐	24 hr Urine ☐
7-15	**2**	EDTA 1 ☐	Serum1 ☐	Serum 2 ☐	Li Hep 1 ☐	Li Hep2 ☐	Fluoride ☐	24 hr Urine ☐		
4-6	**3**	EDTA 1 ☐	Serum1 ☐	Serum 2 ☐	Li Hep 1 ☐	24 hr Urine ☐				
18 mths – 3 yrs	**4**	EDTA 1 ☐	Serum1 ☐	Serum 2 ☐	Li Hep 1 ☐					

3. Date blood sample taken: Day ☐☐ Month ☐☐ Year ☐☐☐☐

4. Time Blood sample taken: 24 hr clock ☐☐ : ☐☐

5. Date blood despatched to Addenbrookes: Day ☐☐ Month ☐☐ Year ☐☐☐☐

6. Date Urine sub-sampled: Day ☐☐ Month ☐☐ Year ☐☐☐☐

7. Did you experience any problems in taking the Venepuncture? If yes, please record these below and state what action you took. (PROMPTED FROM CAPI)