NatCen Social Research

Northern Ireland Statistics & Research agency

MRC Human Nutrition Research

SERIAL NUMBER (8 DIGITS) CKL PARTICIPANT NO.

NDNS NHS (A)

National Diet and Nutrition Survey

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 (NDNS) 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:
  NatCen 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:

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Please initial/tick boxes if consent given

1. I confirm that I have read and understand the NDNS Nurse Visit information sheet(s) dated 05.02.2014 (version 2) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from any part of the study, at any time, without giving a reason and without my medical care or legal rights being affected. ☐

MEASUREMENTS

3. I agree for my blood pressure results to be sent to my GP. ☐

4. I agree for my body mass index (BMI) measurement to be sent to my GP. ☐

Name of participant (please print)	Date	Signature
Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Please initial/tick boxes if consent given

BLOOD SAMPLE

5. I agree to have a blood sample taken as part of the study. ☐

6. I give permission that my blood sample taken as part of this study may be stored and, with ethical approval as appropriate, used in future research studies ☐

7. I would like to receive my blood results which are clinically relevant. ☐

8. I consent to my GP being notified of my blood results which are clinically relevant. ☐

9. **You will be required to consent to the statement below if you do not want to receive your blood results AND if you do not want them sent to your GP.**
I confirm that against the advice of the NDNS survey team, I do not want to receive my blood results which are clinically relevant or have them sent to my GP. I understand that if there are findings outside of the normal range, this will not be brought to the attention of any health care provider. ☐

Name of participant (please print)	Date	Signature

Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER	CHECK LETTER	RESPONDENT No.
☐☐☐☐☐☐☐☐	☐	☐

Name of Child ______________________________

Please initial/ tick boxes if consent given

1. I am the parent/guardian of the child named above and I confirm that I have read and understand the NDNS Nurse Visit information sheet(s) dated 05.02.2014 (version 2) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that my child's participation is voluntary and that s/he is free to withdraw from any part of the study, at any time, without giving a reason and without my medical care or legal rights being affected. ☐

MEASUREMENTS

3. I agree for my child's blood pressure results to be sent to his/her GP. ☐

______________________________	______________	______________________________
Name of Parent/Guardian (please print)	Date	Signature

______________________________	______________	______________________________
Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Name of Child ____________________________

Please initial/tick boxes if consent given

BLOOD SAMPLE

4. I agree to my child having a blood sample taken as part of the study. ☐
5. I give permission that my child's blood sample taken as part of this study may be stored and, with ethical approval as appropriate, used in future research studies ☐
6. I would like to receive my child's blood results which are clinically relevant. ☐
7. I consent to my child's GP being notified of his/her blood results which are clinically relevant. ☐

8. **IF you do not want to receive your child's blood results AND if you do not want them sent to their GP, for us to take a blood sample from your child, you will be required to consent to both of the statements below.**

(i) I confirm that against the advice of the NDNS survey team, I do not want to receive my child's blood results which are clinically relevant or have them sent to his/her GP. ☐

(ii) I agree to the survey doctor contacting me to discuss, if necessary, any results that are directly relevant to my child's health. ☐

Name of Parent/Guardian (please print)	Date	Signature

Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

CHILD ASSENT FORM (5-15 years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

		Please circle
1.	Has somebody explained what happens at the nurse visit?	Yes / No
2.	Do you understand what this study is about?	Yes / No
3.	Have you asked all the questions you want?	Yes / No
4.	Have you had your questions answered in a way you understand?	Yes / No
5.	Do you understand it's OK to stop taking part at any time?	Yes / No
6.	Are you happy to take part?	Yes / No

If any answers are 'No' or you don't want to take part, don't sign your name!

If you do want to take part, you can write your name below.

Your name ______________________________

Date ______________________________

The nurse who explained this study to you needs to sign too:

Nurse name ______________________________

Signature ______________________________

Date ______________________________

Thank you for helping us!

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (1.5-3 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER | | | | | | | | |

CHECK LETTER | |

RESPONDENT No. | |

Please initial/tick boxes if consent given

Name of Child ______________________

1. I am the parent/guardian of the child named above and I confirm that I have read and understand the NDNS Nurse Visit information sheet(s) dated 05.02.2014 (version 2) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that my child's participation is voluntary and that s/he is free to withdraw from any part of the study, at any time, without giving a reason and without our medical care or legal rights being affected. ☐

Name of Parent/Guardian (please print)	Date	Signature
Name of nurse (please print)	Date	Signature

BLOOD SAMPLE

3. I agree to my child having a blood sample taken as part of the study. ☐

4. I give permission that my child's blood sample taken as part of this study may be stored and, with ethical approval as appropriate, used in future research studies. ☐

5. I would like to receive my child's blood results which are clinically relevant. ☐

6. I consent to my child's GP being notified of his/her blood results which are clinically relevant. ☐

☐

7. **IF you do not want to receive your child's blood results AND if you do not want them sent to their GP, for us to take a blood sample from your child, you will be required to consent to both of the statements below.**

   (i) I confirm that against the advice of the NDNS survey team, I do not want to receive my child's blood results which are clinically relevant or have them sent to his/her GP. ☐

   (ii) I agree to the survey doctor contacting me to discuss, if necessary, any results that are directly relevant to my child's health. ☐

Name of Parent/Guardian (please print)	Date	Signature
Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

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: ………………………………………………………

NURSE USE ONLY

GP Address complete	1
GP Address not complete	2
No GP	3

8.

SUMMARY OF CONSENTS—RING CODE FOR EACH ITEM	**YES**	**NO**
a) Read and understood nurse visit information sheet	01	02
b) Understand right to withdraw	03	04
c) Blood pressure to **GP**	05	06
d) Body Mass Index (BMI) to **GP**	07	08
e) Sample of blood to be taken	09	10
f) Blood sample for storage	11	12
g) Blood sample result to **participant**	13	14
h) Blood sample result to **GP**	15	16
i) **Does not** wish to receive results or have them sent to GP	17	18
j) Agrees survey doctor can contact to discuss results if necessary – Children aged 1.5-15 years	19	20

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:

PARTICIPANTS AGED 16+

Priority	Blood Tube	Colour	Label Reference	Laboratory
1	EDTA 2.6 mL	Red	EN1 (3)	Addenbrookes
2	Serum 9.0 mL	White	SEN 1 (4)	Field Lab
3	Li Hep TM 7.5 mL	Orange	LHN1 (5)	Field Lab
4	Li Hep TM 7.5 mL	Orange	LHN2 (6)	Field Lab
5	Fluoride 1.2 mL	Yellow	FN1 (7)	Field Lab
6	Li Hep 4.5 mL	Orange	LHN3 (8)	Field Lab
7	EDTA 2.6 mL	Red	EN2 (9)	Field Lab

PARTICIPANTS AGED 7-15

Priority	Blood Tube	Colour	Label Reference	Laboratory
1	EDTA 2.6 mL	Red	EN1 (3)	Addenbrookes
2	Serum 7.5 mL	White	SEN1 (4)	Field Lab
3	Li Hep TM 7.5 mL	Orange	LHN1 (5)	Field Lab
4	Li Hep 2.7 mL	Orange	LHN2 (6)	Field Lab
5	Fluoride 1.2 mL	Yellow	FN1 (7)	Field Lab

PARTICIPANTS AGED 18 mths – 6 yrs

Priority	Blood Tube	Colour	Label Reference	Laboratory
1	EDTA 2.6 mL	Red	EN1 (3)	Addenbrookes
2	Serum 4.5 mL	White	SEN1 (4)	Field Lab
3	Li Hep 4.5 mL	Orange	LHN1 (5)	Field Lab

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Please initial/tick boxes if consent given

1. I confirm that I have read and understand the NDNS Nurse Visit information sheet(s) dated 05.02.2014 (version 2) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw from any part of the study, at any time, without giving a reason and without my medical care or legal rights being affected. ☐

MEASUREMENTS

3. I agree for my blood pressure results to be sent to my GP. ☐

4. I agree for my body mass index (BMI) measurement to be sent to my GP. ☐

Name of participant (please print)	Date	Signature

Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

ADULT CONSENT FORM (16+ years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Please initial/tick boxes if consent given

BLOOD SAMPLE

5. I agree to have a blood sample taken as part of the study. ☐
6. I give permission that my blood sample taken as part of this study may be stored and, with ethical approval as appropriate, used in future research studies ☐
7. I would like to receive my blood results which are clinically relevant. ☐
8. I consent to my GP being notified of my blood results which are clinically relevant. ☐

9. **You will be required to consent to the statement below if you do not want to receive your blood results AND if you do not want them sent to your GP.**
I confirm that against the advice of the NDNS survey team, I do not want to receive my blood results which are clinically relevant or have them sent to my GP. I understand that if there are findings outside of the normal range, this will not be brought to the attention of any health care provider. ☐

Name of participant (please print)	Date	Signature

Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Please initial/ tick boxes if consent given

Name of Child ______________________________

1. I am the parent/guardian of the child named above and I confirm that I have read and understand the NDNS Nurse Visit information sheet(s) dated 05.02.2014 (version 2) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that my child's participation is voluntary and that s/he is free to withdraw from any part of the study, at any time, without giving a reason and without my medical care or legal rights being affected. ☐

MEASUREMENTS

3. I agree for my child's blood pressure results to be sent to his/her GP. ☐

______________________________ ______________ ______________________________
Name of Parent/Guardian (please print) Date Signature

______________________________ ______________ ______________________________
Name of nurse (please print) Date Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Name of Child ____________________

Please initial/ tick boxes if consent given

BLOOD SAMPLE

4. I agree to my child having a blood sample taken as part of the study. ☐

5. I give permission that my child's blood sample taken as part of this study may be stored and, with ethical approval as appropriate, used in future research studies ☐

6. I would like to receive my child's blood results which are clinically relevant. ☐

7. I consent to my child's GP being notified of his/her blood results which are clinically relevant. ☐

8. **IF you do not want to receive your child's blood results AND if you do not want them sent to their GP, for us to take a blood sample from your child, you will be required to consent to both of the statements below.**

(i) I confirm that against the advice of the NDNS survey team, I do not want to receive my child's blood results which are clinically relevant or have them sent to his/her GP. ☐

(ii) I agree to the survey doctor contacting me to discuss, if necessary, any results that are directly relevant to my child's health. ☐

Name of Parent/Guardian (please print)	Date	Signature
Name of nurse (please print)	Date	Signature

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

CHILD ASSENT FORM (5-15 years)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

		Please circle
1.	Has somebody explained what happens at the nurse visit?	Yes / No
2.	Do you understand what this study is about?	Yes / No
3.	Have you asked all the questions you want?	Yes / No
4.	Have you had your questions answered in a way you understand?	Yes / No
5.	Do you understand it's OK to stop taking part at any time?	Yes / No
6.	Are you happy to take part?	Yes / No

If any answers are 'No' or you don't want to take part, don't sign your name!

If you do want to take part, you can write your name below.

Your name ______________________________

Date ______________________________

The nurse who explained this study to you needs to sign too:

Nurse name ______________________________

Signature ______________________________

Date ______________________________

Thank you for helping us!

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS) Nurse Visit

PARENTAL/GUARDIAN CONSENT FOR CHILD (1.5-3 YEARS)

MREC Reference Number: 13/EE/0016

Please use capital letters and write in ink

SERIAL NUMBER ☐☐☐☐☐☐☐☐ **CHECK LETTER** ☐ **RESPONDENT No.** ☐

Please initial/ tick boxes if consent given

Name of Child ______________________

1. I am the parent/guardian of the child named above and I confirm that I have read and understand the NDNS Nurse Visit information sheet(s) dated 05.02.2014 (version 2) for the above study. I have been given the opportunity to ask questions and have had these answered satisfactorily. ☐

2. I understand that my child's participation is voluntary and that s/he is free to withdraw from any part of the study, at any time, without giving a reason and without our medical care or legal rights being affected. ☐

Name of Parent/Guardian (please print)	Date	Signature
Name of nurse (please print)	Date	Signature

<u>BLOOD SAMPLE</u>

3. I agree to my child having a blood sample taken as part of the study. ☐

4. I give permission that my child's blood sample taken as part of this study may be stored and, with ethical approval as appropriate, used in future research studies. ☐

5. I would like to receive my child's blood results which are clinically relevant. ☐

6. I consent to my child's GP being notified of his/her blood results which are clinically relevant. ☐

☐

7. **IF you do <u>not</u> want to receive your child's blood results <u>AND</u> if you do <u>not</u> want them sent to their GP, for us to take a blood sample from your child, you will be required to consent to both of the statements below.** ☐

   (i) I confirm that against the advice of the NDNS survey team, I do not want to receive my child's blood results which are clinically relevant or have them sent to his/her GP. ☐

   (ii) I agree to the survey doctor contacting me to discuss, if necessary, any results that are directly relevant to my child's health.

Name of Parent/Guardian (please print)	Date	Signature
Name of nurse (please print)	Date	Signature

RESEARCH ANALYSIS REQUEST (v2) 952

Nurses - fill in YELLOW section only

Volunteer Details

Surname: HNR _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
(use 10 digit ID at top of label)

First name: P952

External ID: EN1 _ _ _ _ _ _ _ _ _ _ _ _ _
(use 7 digit no. at bottom of EN1 label)

DOB / / **dd/mm/yyyy**

Male **1**

circle as appropriate

Female **2**

Affix serial number label

Adx1(10)
or
Adx2 (11)
or
Adx3 (12)

Study Details

Consultant Dr Sumantra Ray

Location Project 952

Title NDNS

Contact HNR Switchboard
01223 426356

Sonja Nicholson
Karen Chamberlain
Kate Guberg

Contact OOH Dr Sumantra Ray
0799 062 6671

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
EDTA EN1 red	**Circle as appropriate** **Full tube** **Partial tube**	HbA1C - print 2 labels	LAB90	ENDO BARCODE	Label primary tube with FBC label and pass to Lab Staff for splitting of EDTA - instructions below
		Folate Store - print 3 labels	LAB6108 Database search box will appear, click database lookup tab and select	BIOCHEM BARCODE	
		FBC -print 2 labels	LAB294	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 cancel FBC adding comment: Insufficient sample for Haem in the cancellation comments and white box req comments field.
- Volume very close to 1ml send primary tube to Haem with the pink duplicate request form, cancel the **HbA1c TEST** adding the comment: Insufficient sample for HbA1c in the cancellation comments and white box req comments field.
- Volume more than ~1.5ml proceed to aliquoting whole blood for folate.

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.
Label 2x defrosted 2ml ascorbic acid tubes with HNR barcode labels (FOL1 & FOL2) supplied in the delivery pack, Only label with patient biochem barcodes if there have been no HNR labels (FOL1 &| FOL2) sent.
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 HbA1C then primary tube to Haem with the pink duplicate request form
If there is insufficient volume left for HbA1C, cancel adding the comment: Insufficient sample for HbA1C in the cancellation comments and white box req comments field.

HbA1C

Label 1x 2ml secondary tube with Endo HbA1C barcode
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 HbA1C skip in office

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS)
ADULT FIELD LAB DESPATCH NOTE – 16+ YEARS

Nurse Section

Participant details

Affix label FL1 (13) here

Affix label FL2 (14) on reverse

Sex: **Male / Female**

Fasted sample: **Yes / No**

Sample collection date: DD / MM / YY

Sample collection time: HH : MM 24 hr clock

Checklist
- Samples
- Labels
- Microtubes
- Despatch note

Have you delivered all the items on the checklist to the field lab? **Yes / No**

Time samples delivered to field lab: HH : MM 24 hr clock

Field Lab Section

Date sample arrived: DD / MM / YY

Time sample arrived: HH : MM 24 hr clock

	Blood Monovette Tubes					
	SEN1	LHN1	LHN2	LHN3	FN1	EN2
Sample received?	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**
Is tube full or partial?	**Full / Partial**	**Full / Partial**	**Full / Partial**	**Full / Partial**	**Full / Partial**	**Full / Partial**
Is tube damaged?	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**

Take 1300µl whole blood from well mixed LHN3 tube. Use 2ml microtube. Label with LHWB (15).		
	µl	Volume aliquotted
	HH:MM	Time aliquotted
	HH:MM	Time in freezer

Centrifuge tubes for 20mins at 4°C and 2000g

Time tubes placed in the centrifuge	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM

Did you use a refrigerated centrifuge? **Yes / No**

If **NO**, explain here what you did to keep samples cool:

Describe here any problems or deviations from protocol:	Affix label FL2 (14) here

	Blood Monovette Tubes					
	SEN1	LHN1	LHN2	LHN3	FN1	EN2
Is sample normal?	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**	**Yes/No**
If **NO**, describe e.g. haemolysed, cloudy, clotted, not clotted (SEN1 only)						
Aliquot ALL plasma/serum unless otherwise stated; do not contaminate with cells						
Microtube size	5ml	5ml	5ml	5ml	2ml	2ml
Attach label	SERUM	LIHEP1	LIHEP2	LIHEP3	FLOX	EDTA
Time aliquotted:	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM
Take EXACTLY 300µl plasma from LIHEP1. Use 2ml microtube with green lid containing MPA. Attach label LHMPA (18).		µl	Volume aliquotted			
		HH:MM	Time aliquotted			
		HH:MM	Time in freezer			
Time aliquots in freezer:	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM	HH:MM
Wash red blood cells in monovettes LHN1, LHN2 and LHN3 using saline 3 times. After each wash, centrifuge for 10mins and then discard the supernatant. Place washed red blood cells in their original monovettes in the freezer.						
Time monovettes in freezer:		HH:MM	HH:MM	HH:MM		

Storage Freezer temperature: –________**°C**

Have you completed all relevant fields? **Yes / No**

Print name:_________________ Signature:_______________

Field lab name:_____________________________________

Please fax/ email both sides of this despatch form after sample processing to HNR

FAX: 01223 437546
EMAIL: ndns.fieldlab@mrc-hnr.cam.ac.uk

HNR will arrange for the collection of samples and these forms via courier

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS)
FIELD LAB DESPATCH NOTE – 7 to 15 YEARS

Nurse Section

Participant details

Affix label FL1 (13) here

Affix label FL2 (14) on reverse

Sex: **Male / Female**

Fasted sample: **Yes / No**

Sample collection date: DD / MM / YY

Sample collection time: HH : MM 24 hr clock

Have you delivered all the items on the checklist to the field lab? **Yes / No**

Time samples delivered to field lab: HH : MM 24 hr clock

Checklist
- Samples
- Labels
- Microtubes
- Despatch note

Field Lab Section

Date sample arrived: DD / MM / YY

Time sample arrived: HH : MM 24 hr clock

	Blood Monovette Tubes			
	SEN1	LHN1	LHN2	FN1
Sample received?	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Is tube full or partial?	**Full / Partial**	**Full / Partial**	**Full / Partial**	**Full / Partial**
Is tube damaged?	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
Centrifuge tubes for 20mins at 4°C and 2000g				
Time tubes placed in the centrifuge	HH : MM	HH : MM	HH : MM	HH : MM

Did you use a refrigerated centrifuge? **Yes / No**

If **NO**, explain here what you did to keep samples cool:

Describe here any problems or deviations from protocol:

Affix label FL2 (14) here

	Blood Monovette Tubes			
	SEN1	LHN1	LHN2	FN1
Is sample normal?	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**
If **NO**, describe e.g. haemolysed, cloudy, clotted, not clotted (SEN1 only)				
Aliquot ALL plasma/serum unless otherwise stated; do not contaminate with cells				
Microtube size	5ml	5ml	5ml	2ml
Attach label	SERUM	LIHEP1	LIHEP2	FLOX
Time aliquotted:	HH : MM	HH : MM	HH : MM	HH : MM
Take EXACTLY 300µl plasma from LIHEP1. Use 2ml microtube with green lid containing MPA. Attach label LHMPA (18).		µl	Volume aliquotted	
		HH : MM	Time aliquotted	
		HH : MM	Time in freezer	
Time aliquots in freezer:	HH : MM	HH : MM	HH : MM	HH : MM
Wash red blood cells in monovettes LHN1 and LHN2 using saline 3 times. After each wash, centrifuge for 10mins and then discard the supernatant. Place washed red blood cells in their original monovettes in the freezer.				
Time monovettes in freezer:		HH : MM	HH : MM	

Storage Freezer temperature: −_______ **°C**

Have you completed all relevant fields? **Yes / No**

Print name:_________________ Signature:______________

Field lab name:_____________________________________

Please fax/ email both sides of this despatch form after sample processing to HNR
FAX: 01223 437546
EMAIL: ndns.fieldlab@mrc-hnr.cam.ac.uk
HNR will arrange for the collection of samples and these forms via courier

NatCen Social Research

MRC Human Nutrition Research

National Diet and Nutrition Survey (NDNS)
FIELD LAB DESPATCH NOTE – 1.5 to 6 YEARS

Nurse Section

Participant details

Affix label FL1 (13) here

Affix label FL2 (14) on reverse

Sex: **Male / Female**

Fasted sample: **Yes / No**

Sample collection date: DD / MM / YY

Sample collection time: HH : MM 24 hr clock

Checklist
- Samples
- Labels
- Microtubes
- Despatch note

Have you delivered all the items on the checklist to the field lab? **Yes / No**

Time samples delivered to field lab: HH : MM 24 hr clock

Field Lab Section

Date sample arrived: DD / MM / YY

Time sample arrived: HH : MM 24 hr clock

	Blood Monovette Tubes	
	SEN1	LHN1
Sample received?	**Yes / No**	**Yes / No**
Is tube full or partial?	**Full / Partial**	**Full / Partial**
Is tube damaged?	**Yes / No**	**Yes / No**
Centrifuge tubes for 20mins at 4°C and 2000g		
Time tubes placed in the centrifuge	HH : MM	HH : MM

Did you use a refrigerated centrifuge? **Yes / No**

If **NO**, explain here what you did to keep samples cool:

Describe here any problems or deviations from protocol:	Affix label FL2 (14) here

	Blood Monovette Tubes		
	SEN1	LHN1	
Is sample normal?	**Yes / No**	**Yes / No**	
If **NO**, describe e.g. haemolysed, cloudy, clotted, not clotted (SEN1 only)			
Aliquot ALL plasma/serum unless otherwise stated; do not contaminate with cells			
Microtube size	5ml	5ml	
Attach label	SERUM	LIHEP1	
Time aliquotted:	HH : MM	HH : MM	
Take EXACTLY 300µl plasma from LIHEP1. Use 2ml microtube with green lid containing MPA. Attach label LHMPA (18).		µl	Volume aliquotted
		HH : MM	Time aliquotted
		HH : MM	Time in freezer
Time aliquots in freezer:	HH : MM	HH : MM	
Wash red blood cells in monovette LHN1 using saline 3 times. After each wash, centrifuge for 10mins and then discard the supernatant. Place washed red blood cells in their original monovette in the freezer.			
Time monovette in freezer:		HH : MM	

Storage Freezer temperature: —_______°C

Have you completed all relevant fields? **Yes / No**

Print name:__________________ Signature:_______________

Field lab name:_______________________________________

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1. Participant details

Please affix OFFDESP (2) label here

2. Age group:

16+	EDTA ☐	Serum ☐	Li Hep TM ☐	Li Hep TM ☐
	Fluoride ☐	Li Hep ☐	EDTA ☐	
7-15	EDTA ☐	Serum ☐	Li Hep TM ☐	Li Hep ☐
	Fluoride ☐			
18mths – 6 yrs	EDTA ☐	Serum ☐	Li Hep ☐	

3. Date blood sample taken: DAY: ☐☐ MONTH: ☐☐ YEAR: ☐☐☐☐

4. Time blood sample taken: TIME ☐☐ : ☐☐

5. Date blood despatched to Addenbrookes: DAY: ☐☐ MONT ☐☐ YEAR: ☐☐☐☐

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