





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 <u>not</u> 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	
birth to the National He	consent to the NDNS team passing my name, address and date of alth Service Central Register. I understand that information held by the NHS used to follow up my health status.
Signed	<i>Date</i>





NDNS(N)

National Diet and Nutrition Survey (NDNS)

CONSENT BOOKLET: PERSONAL COPY

Serial Number:						
First Name:						





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

SEI	RIAL	NUN	ИВЕГ	₹					CHE	CK LET	TER			RESP	ONDE	NT No	o.
																	se initial/tickes if consenten
1.	s	heet((s) da	ated	05.0	2.20	14 (ver	sion 2	stand th 2) for the have h	e above	e study.	. I ha	ve be	en give	en	
2.	fr	om	any	part	of th	ie st	udy,	at a	any tir	voluntai me, with ected.							
<u>ME</u>	ASI	<u>JREI</u>	<u>MEN</u>	<u>TS</u>													
3.	I	agre	e for	my	bloo	d pre	essu	re r	esults	to be s	ent to	my GP.					
4.	I	agre	e for	my l	body	ma:	ss in	dex	к (ВМІ	I) meas	uremer	nt to be	sent	to my	/ GP.		
Nam	e of p	partici	pant (pleas	e prin	it)			Date			Signatu	ıre				
Nam	e of r	nurse	(pleas	se pri	nt)				Date			Signatu	ıre				





National Diet and Nutrition Survey (NDNS) Nurse Visit ADULT CONSENT FORM (16+ years)

MR	REC Reference Number: 1	3/EE/0016		
Plea	ase use capital letters and writ	e in ink		
SEF	RIAL NUMBER	CHECK LETTER	RESPOND	ENT No.
				Please initial/tick boxes if consent given
BLO	OOD SAMPLE			
5.	I agree to have a blood san	nple taken as part of t	he study.	
6.	I give permission that my b stored and, with ethical app			
7.	I would like to receive my b	lood results which are	clinically relevant.	
8.	I consent to my GP being n relevant.	notified of my blood res	sults which are clinically	
9.	You will be required to commant to receive your blood your GP. I confirm that against the addreceive my blood results with my GP. I understand that if this will not be brought to the	d results <u>AND</u> if you lvice of the NDNS sun hich are clinically rele f there are findings ou	do not want them sent vey team, I do not want to evant or have them sent utside of the normal rang	to to
Name	e of participant (please print)	Date	Signature	
 Name	e of nurse (please print)	Date	Signature	



MREC Reference Number: 13/EE/0016



National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

Please use capital letters and write in ink **SERIAL NUMBER CHECK LETTER RESPONDENT No.** Please initial/ tick boxes if Name of Child consent given I am the parent/guardian of the child named above and I confirm that I have 1. 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





National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MRI	EC Reference Number: 13/E	E/0016		
Plea	se use capital letters and write ir	n ink		
SER	IAL NUMBER	CHECK LETTER	RESPONDENT	No.
Name	e of Child			Please initial/tick boxes if consent given
BLC	OOD SAMPLE			
4.	I agree to my child having a bl	ood sample taken a	s part of the study.	
5.	I give permission that my child be stored and, with ethical app studies			,
6.	I would like to receive my child	d's blood results which	ch are clinically relevant.	
7.	I consent to my child's GP being clinically relevant.	ng notified of his/her	blood results which are	
8.	to receive my child's bl them sent to his/her GP.	ent to both of the second results which a	ood sample from your chatements below. NS survey team, I do not ware clinically relevant or he discuss, if necessary, any	vant
Name	of Parent/Guardian (please print)	Date	Signature	
Name	of nurse (please print)	Date	Signature	





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 NUM	BER	CHECK LETTER	RESPONDENT No.					
			Please circle					
1. Has sor	nebody explained wha	at happens at the nurse visit	? Yes / No					
2. Do you	understand what this	study is about?	Yes / No					
3. Have yo	ou asked all the questi	ions you want?	Yes / No					
4. Have yo	ou had your questions	answered in a way you und	erstand? 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 <u>any</u> 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 wh	o explained this study	v to you needs to sign too:						
Nurse name								
Signature								
Date								

Thank you for helping us!





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 guestions 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 confirm that against the advice of the NDNS survey team, I do not want (i) 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



1.

3.

4.

6.

7.

8.



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 MONTH: YEAR: DAY: 2. Date schedule Nurse number: completed (all visits complete): Full name (of person tested) Name by which GP knows person (if different) DAY: MONTH: YEAR: Sex Male 5. Date of birth: Female 2 Full name of parent/guardian (if person under 16) **GP NAME AND ADDRESS NURSE USE ONLY** Dr: GP Address complete 1 Practice Name: GP Address not complete 2 Address: No GP 3 Town: County: Postcode: Telephone no:

SUN	IMARY 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
ď)	Body Mass Index (BMI) to GP	07	80
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
li)	Agrees survey doctor can contact to discuss results if necessary –	19	20
1 ′′	Children aged 1.5-15 years		
	3 ,		

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 Refer- ence	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 Refer- ence	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 Refer- ence	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





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

SER	IAL NUMBER	CHECK LETTER	RESPOND	ENT No.				
				Please initial/tick boxes if consent given				
1.	I confirm that I have read and sheet(s) dated 05.02.2014 (ve the opportunity to ask question	ersion 2) for the abov	e study. I have been giv	ven				
2.	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.							
<u>МЕ</u> .	ASUREMENTS I agree for my blood pressure	results to be sent to	my GP.					
4.	I agree for my body mass inde	ex (BMI) measureme	nt to be sent to my GP.					
Name	of participant (please print)	Date	Signature					

Date

Signature

Name of nurse (please print)



MREC Reference Number: 13/EE/0016



National Diet and Nutrition Survey (NDNS) Nurse Visit ADULT CONSENT FORM (16+ years)

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 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





National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MF	REC	Ref	erer	nce	Num	nber:	13/E	E/0016	3						
Ple	ase	use c	apita	al let	ters a	and w	rite in	ı ink							
SE	RIAL	NUN	/BEF	₹				CHEC	K LETTE	R		RES	PONDEN	T No.	
														tick l	se initial poxes if ent give
Nan	ne o	f Chi	ild												
1.	re O:	ead a 5.02.	nd u 2014	ınder 4 (ve	rstan rsior	d the 12) fo	NDN or the	S Nurse above s	e Visit info	orma ave l	and I con ation shee been give actorily.	t(s) da	ted	y to	
2.	W	ithdr	aw fı	rom	any	part	of the	study,		ne, v	ry and tha vithout giv ed.			d	
<u>ME</u> 3.		JREN agree			child'	's blo	od pre	essure r	esults to	be s	sent to his	/her Gl	Ρ.		
		3					•								
						se prin	t)	Date		_	Signature				
Nam	e of n	urse (pieas	se prir	11)			Date			Signature				





National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (4-15 YEARS)

MR	REC Reference Number: 13	/EE/0016		
Ple	ase use capital letters and write	in ink		
SEF	RIAL NUMBER	CHECK LETTER	RESPONDEN	T No.
				Please initial/
Nan	ne of Child			consent given
BL	OOD SAMPLE			
4.	I agree to my child having a	blood sample taken as p	part of the study.	
5.		·	·	
J.	I give permission that my ch be stored and, with ethical a studies			
6.	I would like to receive my ch	ild's blood results which	are clinically relevant.	
7.	I consent to my child's GP b clinically relevant.	eing notified of his/her bl	ood results which are	
8.	IF you do <u>not</u> want to rece want them sent to their G you will be required to con	P, for us to take a bloo	d sample from your ch	
		the advice of the NDNS blood results which are SP.		
		doctor contacting me to d y relevant to my child's h		У
Name	e of Parent/Guardian (please print)	Date S	Signature	
Name	e of nurse (please print)	Date S	Signature	





National Diet and Nutrition Survey (NDNS) Nurse Visit

CHILD ASSENT FORM (5-15 years)

MIKEC	Keierence	Number.	13/22/00 16		
	se capital let	ters and wri			
SERIAL N	NUMBER		CHECK LETTER	RE	SPONDENT No.
					Please circle
1. Has	s somebody	explained	what happens at the nurse	visit?	Yes / No
2. Do	you unders	tand what th	nis study is about?		Yes / No
3. Hav	ve you aske	d all the qu	estions you want?		Yes / No
4. Hav	ve you had y	your questic	ons answered in a way you	understand?	Yes / No
5. Do	you unders	tand it's OK	to stop taking part at any t	time?	Yes / No
6. Are	you happy	to take part	?		Yes / No
		-	on't want to take part, don't		nme!
Your nar	me 				
Date					
The nurs	e wh o expla	ined this st	u dy to you need s to sign to	00:	
Nurse na	ame				
Signatur	 e				
Date					

Thank you for helping us!





National Diet and Nutrition Survey (NDNS) Nurse Visit PARENTAL/GUARDIAN CONSENT FOR CHILD (1.5-3 YEARS)

MREC Reference Number: 13/EE/0016

Plea	ase	eι	ıse	C	apit	al I	ett	ers	an	d v	vrite	ir	ink	K									
SEF	RIA	۱L	NU	M	BE	R —				_		_	С	Н	ECK LETTER	?			RES	POND	ENT	No.	
		1		1																		tick	boxes if
Nam						_																con	sent given
1.		ha 05	ve 5.02	re 2.2	ead 201	an 4 (\	d /ei	und rsio	ers n 2	ta) f	nd to or th	he ne	ND abo	/(C	d named abous Named Named Nurse Vis Named Nurse Vis Named Named Na	sit ir ive l	nformatic been giv	n	sheet	(s) dat		to	
2.		wi	thd	Ira	w f	ron	n a	any	р́аі	rt c	of th	ė s	stuc	yk	pation is volu , at any time ghts being at	, wi	ithout giv						
Name	e of	f P	areı	nt/	Gua	ırdia	n (plea	se p	orir	nt)		D	at	te	_	Signatur	e					
Name	e of	f nu	ırse	; (p	olea	se p	rin	t)			_		Da	ate	e	_	Signature	e	BLO	OD SA	MP	<u>LE</u>	
3.		۱a	gre	ее	to	my	cl	nild	ha	vir	ıg a	bl	ood	1 8	sample taker	n as	part of t	the	e stud	y .			
4.		be		or	ed										ood sample t I as appropr							,	
5.		Ιv	vol	ıld	lik	e to	r	ecei	ive	m	y ch	ilc	i's b	olo	ood results v	vhic	h are cli	nic	cally re	elevant	t.		
6.						to r ele			ld's	s G	SP b	eiı	ng r	าด	otified of his/	her	blood re	su	ılts wh	ich are	9		
7.)	wa	int	th vil	nen II b	e re	en eq n t	t to uire hat	th ed t ag / c	eiı to air hil	GF con nst t d's	e, f se the	for ent	u: to	ur child's bles to take a be both of the lice of the Nicesults which	blo sta	od samp atement S survey	ole ts	e from below eam, I	y our /. do no	chil	ld, ant	
	((ii)													ontacting me nt to my chil			if	neces	sary, a	any		
																_							
Name	e of	f P	areı	nt/	Gua	ırdia	n (plea	se p	orir	nt)		D	at	re	_	Signatur	e e					
Name	e of	f nı	ırse	(r	olea	se p	rin	t)					Di	ate	e		Signature	e					

Nurses - fill in YELLOW section only

Volunteer Details		Study Detai	ls
Surname: HNR (use 10 digit ID at top of label)		Consultant	Dr Sumantra Ray
First name: P952	Affix serial	Location	Project 952
External ID: EN1 (use 7 digit no. at bottom of EN1 label)	number label	Title	NDNS
DOB / / dd/mm/yyyy	Adx1(10) or Adx2 (11) or	Contact	HNR Switchboard 01223 426356
Male 1 circle as appropriate	Adx3 (12)		Sonja Nicholson Karen Chamberlain Kate Guberg
Female 2		Contact OOH	Dr Sumantra Ray 0799 062 6671
C D ''			

Sample Details

Date	/ /	dd/mm/yyyy	Volunteer Fasted	Yes	1	
						circle as appropriate

Time No 2 24hr clock

Sample Tub	е	Tests	Lab order	Lab barcode	Lab processing		
	Circle as appropriate	HbA1C - print 2 labels	LAB90	ENDO BARCODE	Label primary tube		
EDTA EN1 red	Full tube Partial tube	Folate Store - print 3 labels	LAB6108 Database search box will appear, click database lookup tab and select	BIOCHEM BARCODE	with FBC label and pass to Lab Staff for splitting of EDTA - instructions		
		FBC -print 2 labels	LAB294	HAEM BARCODE	below		

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





Checklist

Samples

Microtubes

Despatch note

Yes / No

Labels

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

/ No Fasted sample: Yes

Sample

collection date: DD / MM / YY

Sample

collection time: 24 hr clock HH: MM

Have you delivered all the items on the checklist

to the field lab?

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 Mono	vette 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	
				µl Volume aliquotted			
	e blood from se 2ml micro sel with LHW	otube.	HN3 tube.	нн:мм	Time aliquott	ed	
				нн:мм	Time in freez	er	
	Centrifu	ge tubes for	20mins at 4°	C and 2000g			
Time tubes placed in the centrifuge	нн:мм	нн:мм	нн:мм	нн:мм	нн:мм	нн:мм	

Did you use a refrigerated centrifuge?

Yes / No

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

					Affix FL2 he	(14)
			Blood Monov	ette 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 plas	ma/serum u	nless otherw	vise stated; o	lo not contai	minate with	cells
Microtube size	5ml	5ml	5ml	5ml	2ml	2ml
Attach label	SERUM	LIHEP1	LIHEP2	LIHEP3	FLOX	EDTA
Fime aliquotted:	нн:мм	нн:мм	нн:мм	нн:мм	нн:мм	нн:мм
	_	μl	Volume aliqu	iotted		
Take EXACTLY 300µl pl LIHEP1. Use 2ml micro green lid containin	otube with g MPA.	HH:MM Time aliquotted				
Attach label LHMP	A (18).	нн:мм	Time in freez	zer		
Time aliquots in freezer:	HH:MM	нн:мм	нн:мм	HH:MM	нн:мм	нн:мм
Wash red blood cells centrifuge for 10mins a	in monovettes nd then disca	rd the supern	and LHN3 usi atant. Place w n the freezer.	ng saline 3 tir ashed red blo	nes. After eac od cells in the	h wash, ir original
Time monovettes in freezer:		HH:MM	нн:мм	нн:мм		
round European house	**************************************	°C	•			
orage Freezer tempe						
ave you completed al	ı relevant fi	eids?	Yes / No)		
int name:		Signatur	e:			
eld lab name:						

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

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





Checklist

Samples

Microtubes

Despatch note

Yes / No

Labels

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?

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 Mond	ovette 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	C and 2000g	
Time tubes placed in the centrifuge	нн : мм	нн : мм	нн : мм	нн : мм

Did you use a refrigerated centrifuge?

Yes / No

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

				Affix label FL2 (14) here
			vette 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 plasm	ma/serum unless oth	erwise stated; o	do not contaminate	e with cells
Microtube size	5ml	5ml	5ml	2ml
Attach label	SERUM	LIHEP1	LIHEP2	FLOX
Time aliquotted:	HH : MM	HH : MM	HH : MM	HH : MM
- 1		μΙ	Volume aliquotted	
Take EXACTLY 300µl plants Use 2ml microtube containing MPA. Attach	with green lid		Time aliquotted	
3		HH : MM	Time in freezer	
Time aliquots in freezer:	HH : MM	нн : мм	HH : MM	HH : MM
Wash red blood ce centrifuge for 10mins an	lls in monovettes LHN1 nd then discard the sup monovett	and LHN2 using ernatant. Place wes in the freezer.	ashed red blood cell	each wash, s in their original
Time monovettes in freezer:		HH : MM	HH : MM	
torage Freezer temper	rature:°C		1	
ave you completed all	relevant fields?	Yes / N	0	
rint name:	Signa	ture:		
ield 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

Describe here any problems or deviations from protocol:





Checklist

Samples

Microtubes

Despatch note

Labels

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

Male /	Female
	Male /

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 Yes / No

to the field lab?

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:	

			Affix label FL2 (14) here	
		ovette 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	a/serum unless otherwise stated; d	o not contam	inate with cells	
Microtube size	5ml		5ml	
Attach label	SERUM	LIHEP1		
Time aliquotted:	HH : MM	HH : MM		
		μl	Volume aliquotted	
Take EXACTLY 300µl plasma from LIHEP1. Use 2ml microtube with green lid containing MPA. Attach label LHMPA (18).		HH: MM	Time aliquotted	
		HH: MM	Time in freezer	
Time aliquots in freezer:	HH : MM		HH : MM	
Wash red blood cells in mor then discard the superna	novette LHN1 using saline 3 times. After tant. Place washed red blood cells in the	r each wash, ce eir original mor	entrifuge for 10mins and novette in the freezer.	
Time monovette in freezer:			HH : MM	
Storage Freezer tempera				
lave you completed all r	relevant fields? Yes / No			
Print name:	Signature:			

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

Field lab name:

Describe here any problems or deviations from protocol:

1.	Participant details	Please af OFFDESP label he	(2)			
2.	Age group:	16+	EDTA Fluoride	Serum Li Hep	Li Hep TM EDTA	Li Hep TM
		7-15	EDTA Fluoride	Serum	Li Hep TM	Li Hep
	18mth	ıs – 6 yrs	EDTA	Serum	Li Hep	
3.	Date blood sa	·		DAY:		YEAR:
4.5.	Time blood sample taken: DAY: MONT YEAR: Date blood despatched to Addenbrookes:					
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)						