



Interviewer #1 Code: \_\_\_\_ \_\_\_\_ \_\_\_\_

If needed,

Interviewer #2 Code: \_\_\_\_ \_\_\_\_ \_\_\_\_

Interviewer #3 Code: \_\_\_\_ \_\_\_\_ \_\_\_\_

Interviewer #4 Code: \_\_\_\_ \_\_\_\_ \_\_\_\_

Circle Field Center Location:

**BU**

**CU**

**DK**

**UP**

Circle Visit:            <sup>1</sup>Visit 1            <sup>3</sup>Visit 2            <sup>4</sup>Visit 2 (New Participant)

Form Version Date: **15/12/2014**

### Visit 2 Length Tracking

# LLFS participants included in visit: \_\_\_\_\_ # LLFS Staff performing visit: \_\_\_\_\_

**Please enter each participant's data into REDCap separately**

	Participant #1	Participant #2	Participant #3	Participant #4	Participant #5	Participant #6
Participant LLFS ID						
Visit 2 Date (DD/MM/YYYY)	___/___/____	___/___/____	___/___/____	___/___/____	___/___/____	___/___/____
In-Home Visit Start Time	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
<b>Cognitive Battery</b>						
Time Start	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
Time End	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
<b>Carotid Ultrasound</b>						
Time Start	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
Time End	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
In-Home Visit End Time	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
Multiple Days to Complete V2?	<input type="checkbox"/> <sup>1</sup> Yes <input type="checkbox"/> <sup>0</sup> No	<input type="checkbox"/> <sup>1</sup> Yes <input type="checkbox"/> <sup>0</sup> No	<input type="checkbox"/> <sup>1</sup> Yes <input type="checkbox"/> <sup>0</sup> No	<input type="checkbox"/> <sup>1</sup> Yes <input type="checkbox"/> <sup>0</sup> No	<input type="checkbox"/> <sup>1</sup> Yes <input type="checkbox"/> <sup>0</sup> No	<input type="checkbox"/> <sup>1</sup> Yes <input type="checkbox"/> <sup>0</sup> No

If Yes to multiple days for V2, complete page 2 for additional days

LLFS V2: VisitLengthTracking\_12152014\_v5



Interviewer #1 Code: \_\_\_\_\_

If needed,

Interviewer #2 Code: \_\_\_\_\_

Interviewer #3 Code: \_\_\_\_\_

Interviewer #4 Code: \_\_\_\_\_

Circle Field Center Location:

**BU**

**CU**

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Circle Visit:            <sup>1</sup>Visit 1            <sup>3</sup>Visit 2            <sup>4</sup>Visit 2 (New Participant)

Form Version Date: 15/12/2014

### Visit 2 Length Tracking— Return Day(s)

# LLFS participants included in visit: \_\_\_\_\_ # LLFS Staff performing visit: \_\_\_\_\_

**Please enter each participant's data into REDCap separately**

	Participant #1	Participant #2	Participant #3	Participant #4	Participant #5	Participant #6
Participant LLFS ID						
<b>Visit 2 Date (DD/MM/YYYY)</b>	___/___/_____ /____	___/___/_____ /____	___/___/_____ /____	___/___/_____ /____	___/___/_____ /____	___/___/_____ /____
<b>In-Home Visit Start Time</b>	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
<b>Cognitive Battery</b>						
Time Start	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
Time End	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
<b>Carotid Ultrasound</b>						
Time Start	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
Time End	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm
<b>In-Home Visit End Time</b>	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm	___:___ <input type="checkbox"/> <sup>A</sup> am <input type="checkbox"/> <sup>P</sup> pm

