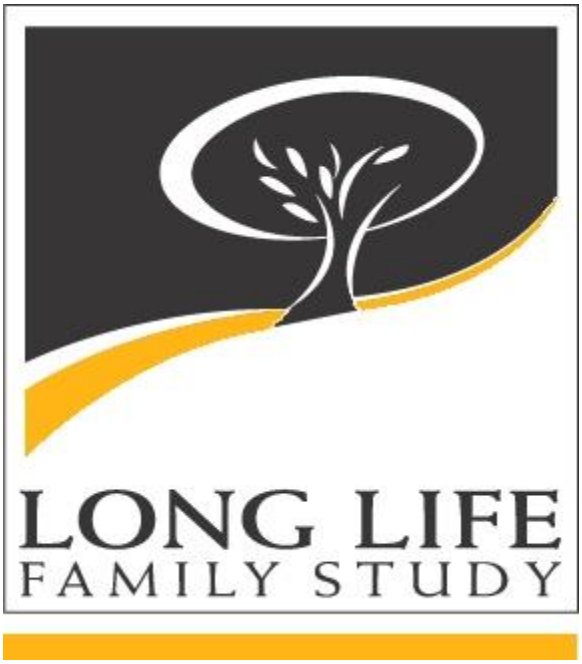

LLFS Visit 3 Results Letters and Medical Record Release Authorization

Authorization to Release Protected Health Information for Research

Participant Name _____ Date of Birth _____

I authorize _____to release information from the record of_____
Hospital/Provider Participant

to the **Long Life Family Study (LLFS)** at (enter site name). The reason for this request is that I am a participant in this research study. These records are for **research purposes only**, and are not being used for patient care. I authorize a photocopy or facsimile of this authorization to be acceptable and valid. I authorize this release to be valid from 2021-2030. I understand that I may revoke this authorization in writing at any time by providing a request to the study. I understand that once this information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. My request to release these records to LLFS will have no impact on the releasing facility's provision of care to me.

The records to be released are for the treatment dates: __ __/__ __/__ __to __ __/__ __/__ __

___ Face Sheet/Attestation with ICD codes

___ Admitting History & Physical Exam

___ Emergency Room Report

___ Operative Reports

___ Echocardiography Reports

___ Cardiac Catheterization Reports

___ Carotid Duplex/Angiography Reports

___ Lung/VQ Scan Reports

___ Neurological Records

___ ERA/PRA Hormone receptors (breast cancer)

___ Discharge/Death Summary

___ Consult (specify_____)

___ Laboratory Reports

___ Radiology Reports

___ Stress Test Reports

___ ECG tracings

___ Lower Extremity Duplex/Angiography

___ Pathology Reports

___ X-Rays, CT Scans, MRI, etc.

___ Behavioral Health, Drug/Alcohol Communicable Disease, or HIV/AIDS

___Other _____

___ All records for a diagnosis of: _____

_____
Participant/ Representative Signature Date

_____ _____
Relationship to participant, if representative Witness Signature Date

Please release my medical records via MAIL/FAX to:
Long Life Family Study
(enter site info here)

Visit 3 Results Report

We would like to thank you for your participation in The Long Life Family Study. These tests were done for research purposes only and were not intended to diagnose any health problems. We encourage you to share them with your doctor. If you have any questions, please call XXXX, LLFS Study Coordinator at XXX-XXX-XXXX.

Name: _____

Date of Visit: _____

Blood Pressure

_____ _____ _____ / _____ _____ _____ **mm HG**

Systolic **Diastolic**

		Systolic	Blood	Pressure	(mm Hg)
		<120	**120-129**	**130-139**	**≥140**
Diastolic	**<80**	Normal	Elevated	Stage 1	Stage 2
Blood	**80-89**	Stage 1	Stage 1	Stage 1	Stage 2
Pressure (mm Hg)	**≥90**	Stage 2	Stage 2	Stage 2	Stage 2

From: American College of Cardiology/American Heart Association 2017 recommended Blood Pressure guidelines. Classification based on the average of two or more readings on two or more occasions.

Follow-up Criteria for Initial BP Measurement for Adults Aged 18 Years or Older[3]:

BP Range, mm Hg	Recommended Follow-up
Diastolic BP:	
< 80	Have your blood pressure rechecked within 2 years
80-89	Have your blood pressure rechecked within 1 year
90-99	See your doctor about your blood pressure within 2 months
100-109	See your doctor about your blood pressure within 1 month
110- 119	See your doctor about your blood pressure within 2 weeks
≥120	See your doctor about your blood pressure immediately
Systolic BP, when DBP <90 mm Hg:	
< 120	Have your blood pressure rechecked within 2 years
120-139	Have your blood pressure rechecked within 1 year
140-159	See your doctor about your blood pressure within 2 months
160-179	See your doctor about your blood pressure within 1 month
180-209	See your doctor about your blood pressure within 2 weeks
≥210	See your doctor about your blood pressure immediately

[3]When recommendations for follow-up of diastolic blood pressure and systolic blood pressure are different, the shorter recommended time for recheck and referral should take precedence.

Based on your blood pressure taken today, it is recommended that you:

- ☐ Have your blood pressure rechecked within 2 years
- ☐ Have your blood pressure rechecked within 1 year
- ☐ Have your blood pressure rechecked within 2 months
- ☐ See your doctor about your blood pressure within 1 month
- ☐ See your doctor about your blood pressure within 2 weeks
- ☐ See your doctor about your blood pressure immediately

If you have any specific questions about your blood pressure, please talk with your doctor.

Body Composition

Height: _____ **cm** _____ **feet** _____ **inches**

Weight: _____ _____ **kg** _____ _____ _____ **pounds**

Body Mass Index: Body mass index (BMI) is a measure of body fat based on height and weight that applies to both adult men and women. The left column lists height. Move across to a given weight (in pounds). The number at the top of the column is the BMI at that height and weight. Pounds have been rounded off.

BMI less than 25 is normal; 25.0 to 29.9 is overweight; 30 or greater is obese. BMI may **overestimate** body fat in athletes and others who have a muscular build or **underestimate** body fat in older persons and others who have lost muscle mass.

BMI	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
Height (ft, in)	Body Weight (pounds)																
4’10’’	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
4’ 11”	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
5’ 0”	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
5’ 1”	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
5’ 2”	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191
5’ 3’	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197
5’ 4’	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
5’ 5”	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
5’ 6”	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
5’ 7”	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
5’ 8”	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
5’ 9”	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
5’ 10”	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243
5’ 11”	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
6’ 0”	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258
6’ 1”	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
6’ 2”	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
6’ 3”	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
6’ 4”	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

Ankle-Arm Blood Pressure

Peripheral arterial disease is a blockage of the arteries in the legs that can show up as a reduced systolic blood pressure in the legs. During your visit, the systolic blood pressure of the arms and ankles were measured. The results of the ratio between your ankle systolic blood pressure and your arm systolic blood pressure is shown in the table below.

Normal results are ankle/arm ratios >0.9 and <1.30.

Your results were:

Blood Flow Measurement Results

	Ankle/ Arm Ratio	Normal	Out of Range
Left leg			
Right leg			

A blockage in the legs, usually due to atherosclerosis, frequently means there could be atherosclerosis in other parts of the body, including the heart and brain. This test was done for research purposes only and was not intended to diagnose any health problems. However, we encourage you to share these results with your doctor.

LONG LIFE
FAMILY STUDY

A Collaborative Study, Including:
Boston University Medical Center
Columbia University
University of Pittsburgh
University of Southern Denmark
Washington Univ. School of Medicine

Sponsored by:
National Institute on Aging

Date

Dear [participant]:

Thank you for participating in the Long Life Family Study. Enclosed are the results from your blood sample analysis. I have enclosed an extra copy of your results for you to share with your physician.

These results will be used to describe the health status of families in this observational study. These tests are not intended to replace any test that your doctor may order for a specific reason, but do provide us with information about your health.

Your participation in this study represents an important, valuable contribution. We will keep in touch yearly as promised. Meanwhile, please call us at _____ if you have any questions about this report. Again, we appreciate time you spent with us.

Sincerely,

[name]
Long Life Family Study

Enc: Lab Report

A Collaborative Study, Including:
Boston University Medical Center
Columbia University
University of Pittsburgh
University of Southern Denmark
Washington Univ. School of Medicine

Sponsored by:

National Institute on Aging

Date

Dear XXX,

Thank you for participating in the Long Life Family Study. Enclosed are the results from your blood sample analysis. As we discussed on the phone, please note that your [list the values that were out of range] was/were out of range. I have enclosed an extra copy of your results that I encourage you to share with your doctor.

These results will be used to describe the health status of families in this observational study. These tests are not intended to replace any test that your doctor may order for a specific reason, but do provide important information about your health.

Your participation in this study represents an important, valuable contribution. We will keep in touch yearly as promised. Meanwhile, please call us at xxx-xxx-xxxx if you have any questions about this report. Again, we appreciate the time you spent with us.

Sincerely,

[clinic coordinator/study nurse]

Enc: Blood Analysis

A Collaborative Study, Including:
Boston University Medical Center
Columbia University
University of Pittsburgh
University of Southern Denmark
Washington Univ. School of Medicine

Sponsored by:
National Institute on Aging

[DATE]

[PHYSICIAN NAME]
[ADDRESS]
[CITY, STATE, ZIP CODE]

Dear Dr. [INSERT NAME]:

Your patient, XX, is participating in the Long Life Family Study, an observational study of exceptional survival in families. As part of this research study several blood tests were performed on [Insert Date]. [Because of unanticipated and/or clinically significant findings, a copy of the results is attached for your review.]

[PI may insert narrative here, if needed.]

All tests were performed for research purposes only and will be used to describe the health status of men and women who are taking part in this study.

These tests are not intended to replace any tests that might be ordered for a specific clinical indication. Although we do not suggest specific diagnosis or treatment, we hope this information is useful to you and your patient. If you have any questions, please feel free to contact XXXX at the [insert name of site], at [phone].

Thank you for your support.
Sincerely,

Site Principal Investigator
Long Life Family Study

Site Physician
Long Life Family Study

Enc: Blood Analysis

LONG LIFE FAMILY STUDY

A Collaborative Study, Including:
Boston University Medical Center
Columbia University
University of Pittsburgh
University of Southern Denmark
Washington Univ. School of Medicine

Sponsored by:
National Institute on Aging

«vFirstName» «vLastName» «sSuffix»
«vAddressLine1»
«vAddressLine2»
«vCity», «sState» «sPostalCode_5»

Date>>

Dear «FirstName» «LastName»,

Thank you for participating in the Long Life Family Study! Your COVID-19 antibody test results are enclosed on the attached sheet. Antibodies are produced by your body in response to an infection; the next time you are exposed to that same disease, they can help your body to fight the infection so you don't get sick. An antibody test can tell us if you have been exposed to or experienced a certain disease, like COVID-19. The tests can also tell us if you have made antibodies in response to a vaccination. We performed two COVID-19 antibody tests to help us determine this; the two tests look for reactions to different parts of the COVID-19 virus particle: the "nucleocapsid" and the "spike receptor binding domain (RBD)". Each of these tests reacts differently, depending on whether or not your antibodies are produced in response to having had COVID-19 or having received the vaccination.

Note, these test results are for research purposes and do not take the place of tests recommended or performed by your doctor. If you have any questions about any of these results please contact your doctor or health care provider.

Guidelines for interpreting your individual test results (highlighted in the table) are as follows:

Anti-nucleocapsid antibodies	**Anti-spike RBD antibodies**	**Interpretation**
Negative	Negative	Negative for antibody response to past COVID-19 infection or vaccination
Negative	Positive	Positive for antibody response to vaccination. In rare cases this pattern may also be seen in individuals with past COVID-19 infection who did not make anti-nucleocapsid antibodies.
Positive	Negative	Positive for antibody response to past COVID-19 infection, negative for antibody response to vaccination
Positive	Positive	Positive for antibody response to past infection, OR positive for antibody response to both past COVID-19 infection and vaccination

If you have any additional questions about the Long Life Family Study, please contact us at XXXXXX. We look forward to your continued interest and participation in all aspects of this important study.

Sincerely,

[PI Name]

Name: <<LAST>>, <<FIRST>>

Results provided by:

Advanced Research and Diagnostic Laboratory
University of Minnesota
1200 Washington Avenue South, Suite 175
Minneapolis, MN 55455
Tel. (612) 625-5040

CAP and CLIA Accredited CAP
Number: 7533346 CLIA ID:
24D2184437

ID: 12345678

Collection Date: 06/17/2016 9:52 AMs Received
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06/18/2016 8:00 AM