OMB # 0925-0414 Exp: 4/06

- Affix label here-

Clinical Center/ID: __ __ __ __ - ___ ___ ___ - __

First Name ________________________M.I.______

Last Name ________________________________

URINE COLLECTION

1. Date Collected: [|]-[|]-[|] (M/D/Y)
2. Collected By: [| |] ____________________
3. Contact Type:
   - ☐1 Phone
   - ☐2 Mail
   - ☐3 Visit
   - ☐8 Other
4. Visit Type:
   - ☐1 Screening # [ ]
   - ☐2 Semi-Annual # [|]
   - ☐3 Annual # [|]
   - ☐4 Non-Routine
5. Time Collected: [|] : [|] (Hr:Min) ☐1 AM ☐2 PM
6. WHI Urine Sample Number

   -Affix Urine "Form" label here-

URINE PROCESSING

7. Processed by: [| |] ____________________
8. Time began centrifugation: [|] : [|] (Hr:Min) ☐1 AM ☐2 PM
9. Time sample placed in cryovial: [|] : [|] (Hr:Min) ☐1 AM ☐2 PM
10. Time cryovials placed in freezer: [|] : [|] (Hr:Min) ☐1 AM ☐2 PM
11. Aliquots:

Sample Size	Aliquot Color	11.1. Cryovial Number	11.2. Mark if urine placed in cryovial
1.8 ml	green	1 7	☐1
1.8 ml	green	1 8	☐1
1.8 ml	green	1 9	☐1

K __________