

The NSW CLEAR Study

Cancer, Lifestyle and Evaluation of Risk Study

Participant Consent Form

Participant Details

Mr Mrs Miss Ms Other _____

Family Name: _____ First Given Name: _____

Other Given Name(s): _____

Address: _____

Phone Number: _____

Email: _____

Date of Birth: / /
Day Month Year

I agree to take part in the NSW CLEAR Study and consent on the understanding that:

- The Study will be done as described in the CLEAR Study Participant Information Sheet, which I have read and understood.
- I have read the Participant Information Sheet, which explains why I have been invited, the aims of the study, and the nature and the possible risks of the Study.
- Before signing this consent form, I have been given the opportunity of asking any questions about the Study including those relating to any possible physical and mental harm I might suffer as a result of my participation, and I have received satisfactory answers.
- I can withdraw from the Study at any time without prejudice to my relationship to the Cancer Council NSW, or my health care providers.
- That data gathered relating to my questionnaire or blood/tissue sample may be published, in ways that do not identify me.
- Results from any test or analyses will be incorporated back into the CLEAR Study for use in future research.
- If I have any questions relating to my participation in this Study, I may contact the Study on 1800 500 894.
- I may keep copies of this Consent Form and the Participant Information Sheet.
- I permit researchers to contact me to participate in follow-up research, my participation in this will be entirely voluntary.
- The Study will follow my health over time by accessing and linking my health records from NSW hospitals, cancer and death registers and other health-related record collections, as outlined in the Participant Information Sheet.

Please tick one:

- I have been diagnosed with cancer in the last 18 months.
- I have never been diagnosed with cancer.

Optionally, I agree to (Please circle Yes or No)

- Give a blood sample to the Study, and permit the long term use and storage of the sample and test results. I understand that generally no results will be communicated back to me as stated in the Participant Information Sheet. *(If Yes, you will be sent a blood collection form listing nearby blood collection centres.)* Yes No
- Permit researchers to ask for samples of the tissue I gave to the pathologist who diagnosed my cancer. *(Only for participants with a cancer diagnosis)* Yes No

(If Yes, please name the Hospital or Medical Centre where surgery was performed.)

- Permit study investigators to access my dental records. *(If Yes, please provide details)* Yes No

Dentist's Name: _____

Address: _____

Telephone: _____

Signature of Participant: _____

Date (Today's date): / /
Day Month Year

If your spouse or partner is also enrolled in the Study, please provide their name

Given Name: _____ Surname: _____

I would / I would not *(please delete where applicable)* like to receive Study newsletters by post or by email *(please delete where applicable)*

Complaints may be directed to the St Vincent's Hospital Research Office, on (02) 8382 2075

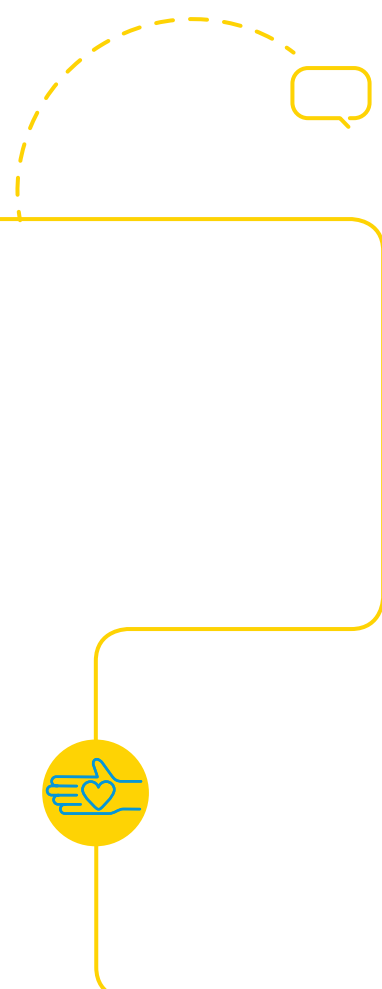
Thank you for participating in the NSW CLEAR Study.

The NSW Cancer, Lifestyle and Evaluation of Risk (CLEAR) Study

Questionnaire For Men

All of your answers will be kept confidential

- Your answers are important to us. Please answer every question. If you are not sure of the right dates or ages, your best guess is better than leaving it blank.
- The study is looking at the possible relationship between ordinary behaviours (“lifestyle”) and having been diagnosed with cancer. The questions cover a range of activities that may, or may not, be connected with cancer. Asking you about these things does not mean that we think they cause cancer. What we hope is that everyone’s answers will reveal any overall patterns of the relationship between ordinary activities and illness.
- If you are a cancer patient, please answer the questions thinking of the time just before you became ill with this cancer.
- If you are a spouse or partner of a cancer patient, please answer the questions thinking of the time just before your spouse/ partner became ill with this cancer.
- Please answer the questions about yourself and your own experience, not your partner’s experience.
- Please write clearly using BLACK or BLUE ink. Put a cross (X) in the appropriate box(es) OR put numbers in the appropriate box(es)
e.g. 2nd December 1942 / /
- If you make a mistake or change your mind please draw a line through that answer and write the correct answer next to it
e.g. ~~25~~ 36
- A glossary explaining some of the terms used in this questionnaire appears on the last page.



CLEAR, Reply Paid 79819, Potts Point NSW 1335. Study Call Centre 1800 500 894
clear@nswcc.org.au www.clearstudy.org.au

Questions About Your, Or Your Partner's, Diagnosis

Today's date: (day/month/year) / / What is your postcode?

1. What is your reason for participating in this study? Answer either (A) or (B)

(A) **YOU** were recently diagnosed with cancer

a) If yes, what is your cancer type?

- Type: ¹ Prostate cancer
² Bowel cancer
³ Lung cancer
⁴ Melanoma
⁵ Other cancer, please specify:

b) Date you were diagnosed with cancer:

/
 Month Year

c) Have you had treatment for this cancer?

¹ Yes ² No

d) If yes, what treatment have you had?

(please cross (X) all that apply)

- | | Month | | Year |
|--|---|---|---|
| ¹ <input type="checkbox"/> Surgery | <input type="text"/> <input type="text"/> | / | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| ² <input type="checkbox"/> Radiotherapy | <input type="text"/> <input type="text"/> | / | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| ³ <input type="checkbox"/> Chemotherapy | <input type="text"/> <input type="text"/> | / | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| ⁴ <input type="checkbox"/> Hormonal Therapy | <input type="text"/> <input type="text"/> | / | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| ⁵ <input type="checkbox"/> Other | <input type="text"/> <input type="text"/> | / | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |

please specify:

(B) **YOUR SPOUSE/PARTNER** was recently diagnosed with cancer

a) If yes, spouse / partner's cancer type?

- Type: ¹ Breast cancer
² Bowel cancer
³ Lung cancer
⁴ Melanoma
⁵ Other cancer, please specify:

b) Date your spouse / partner was diagnosed with cancer

/
 Month Year

OR

2. In the year prior to your, or your partner's, diagnosis, approximately how many times did you visit a doctor?

- ¹ None - *please go to question 4*
² 1-2 times
³ 3-5 times
⁴ 6-10 times
⁵ more than 10 times

3. What kind of doctor(s) did you visit?

(Cross (X) all that apply)

- ¹ Regular general practitioner (GP) or family doctor
² Other GP or medical centre
³ Specialist doctor(s), please specify the speciality:

Questions About Your Health

54. Has a doctor EVER told you that you had: (If yes, please cross (X) the box and give your age when the condition was first found)

| | Yes | Age Diagnosed |
|------------------------------|--------------------------|---|
| 1 Skin cancer (not melanoma) | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 2 Melanoma | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 21 Prostate cancer | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 4 Other cancer | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| Please specify: | | |

| | | |
|--------------------------------------|--------------------------|---|
| 5 Thyroid problems | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 6 Pre-Diabetes/Diabetes | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 7 Sleep Apnoea | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 8 Asthma or hay fever | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 9 Stomach/peptic ulcer | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 10 Heartburn | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 11 Liver disease | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 12 Celiac/Coeliac disease | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 13 Pancreatitis | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 14 Crohns disease | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 15 Colitis | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 16 Diverticulitis | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 22 Intestinal polyps | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 23 Enlarged prostate | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 24 Prostatitis/infection of prostate | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 25 None of these | <input type="checkbox"/> | |

55. Before you, or your partner, became ill, were you ever treated for: (If yes, please cross (X) the box and give your age when the treatment started)

| | Yes | Age when treated |
|---------------------------------|--------------------------|---|
| 1 Cancer (a previous diagnosis) | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 2 Asthma | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 3 Hay fever | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 4 Thyroid problems | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 5 Diabetes Type 1 | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 6 Diabetes Type 2 | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 7 None of the above | <input type="checkbox"/> | |

56. a) Before you, or your partner, became ill, did you experience any of the following? (Cross (X) all that apply)

| | In the past year | In the past 5 years |
|---|--------------------------|----------------------------|
| 1 <input type="checkbox"/> Death of a spouse or close family member | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 <input type="checkbox"/> Divorce or marital separation | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 <input type="checkbox"/> Retirement/your partner's retirement | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 <input type="checkbox"/> Change of residence | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 <input type="checkbox"/> None of the above | <input type="checkbox"/> | <input type="checkbox"/> |

57. Have you ever had any of the following operations/procedures? (If yes, please cross (X) the box and give your age when you had the operation/procedure; give your age at the most recent operation/procedure if you have had more than one. Do NOT include operations/procedures since you, or your partner, became ill)

| | Yes | Age at Operation |
|---|--------------------------|---|
| 1 Blood transfusion | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 12 Vasectomy | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 13 Removal of part of prostate | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 14 Removal of whole of prostate | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 6 Repair of prolapsed bladder or bowel | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 7 Removal of gall bladder | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 8 Heart/coronary bypass surgery (including stents and angioplasty balloons, see glossary) | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 9 Organ transplant | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 10 Procedure to cure ulcers | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 11 Removal of intestinal polyps | <input type="checkbox"/> | <input type="text"/> <input type="text"/> |
| 15 None of the above | <input type="checkbox"/> | |

58. a) Have you been vaccinated against the Human Papillomavirus (HPV), such as Gardasil or Cervarix? (Please cross (X) yes if you have had one or more doses of the vaccine)

- 1 Yes
 2 No - please go to question 59
 3 Don't know

b) If yes, about what year were you vaccinated? (If you do not recall, please provide your 'best guess')

(year)
 Can't remember

c) How many shots of vaccine did you receive?

_____ shots
 Can't remember



Cancer Council
Helpline
13 11 20

For more information

Call 1800 500 894 or
www.clearstudy.org.au