S33r0 Child Health Questionnaire Transmittal Form

Patient's Identification Number ______________________________

Visit Date (yyyy/mm/dd): ______________________________

Correction:
- ☐ Yes
- ☐ No

1. Child Health Questionnaire completion date (yyyy/mm/dd): ______________________________

2. Child Health Questionnaire:
- ☐ Study entry
- ☐ Study conclusion

Mail the Child Health Questionnaire to Washington University Statistical Data Coordinating Center, 660 South Euclid Avenue, Box 8203, Saint Louis, Missouri 63110

3. Date Child Health Questionnaire was mailed (yyyy/mm/dd): ______________________________

Staff I.D. #: ______________________________