C
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Childhood Adenotonsillectomy Study
Adverse Event

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __

AE #	CTCAE Name Please use CTCAE code number	Event Name	Date of Onset	Grade	Relationship to Study Treatment	Action taken regarding Study Treatment	Treatment for event	Seriousness	Date of Resolution Enter date OR check box if AE is continuing	Was Event Serious?
			mm/dd/yyyy	1.Mild 2.Moderate 3.Severe 4.Life threatening or disabling 5.Fatal record one	1.Unrelated 2.Possibly related 3.Probably 4.Definitely related record one	0.No action taken 1.Treatment interrupted 2.Treatment discontinued record one	0.No 1.Yes record one	See key below table record most appropriate	mm/dd/yyyy	0.No 1.Yes Yes, if Seriousness 3-8
			__ __/__ __/__ __ __ __						__ __/__ __/__ __ __ __ ☐	
			__ __/__ __/__ __ __ __						__ __/__ __/__ __ __ __ ☐	
			__ __/__ __/__ __ __ __						__ __/__ __/__ __ __ __ ☐	
			__ __/__ __/__ __ __ __						__ __/__ __/__ __ __ __ ☐	
			__ __/__ __/__ __ __ __						__ __/__ __/__ __ __ __ ☐	
			__ __/__ __/__ __ __ __						__ __/__ __/__ __ __ __ ☐	

Seriousness Key
1.Resolved/ no follow-up needed
2.On-going/treatment continued
3.Hospitalization or prolongation of existing hospitalization
4.Resulted in persistent or significant disability/ incapacity
5.Congenital anomaly/ birth defect
6.Life threatening
7.Fatal
8.Other Important Medical Event/SAE

CHILDHOOD ADENOTONSILLECTOMY STUDY
Anthropometry
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Date of the current measurements: __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

2. Time of the current measurements: ___ ___ : ___ ___ (24 Hour Clock)

3. What is the child's current standing height? __ __ __ . __ __ cm

4. What is the child's current weight? __ __ __ . __ __ kg

5. What is the child's current BMI? __ __ __ . __ __

Please note, after BMI is calculated by the DMS write the result in the shaded area

5a. What is the child's BMI z-score? __ . __ __
☐ 99 Not required at this visit

*Please note, the BMI z-score be obtained from the following website:
http://www.bcm.edu/cnrc/bodycomp/bmiz2.html *

* Also note – the BMI z-score is only collected at the Baseline visit *

Body Measurements:

*** Please note, AVERAGE totals for Neck, Waist, and Hip Circumference will be calculated by the DMS ***

		Measurement 1	Measurement 2	Measurement 3	Average
6.	Neck Circumference:	__ __ __ . __ cm	__ __ __ . __ cm	__ __ __ . __ cm	__ __ __ . __
7.	Waist Circumference:	__ __ __ . __ cm	__ __ __ . __ cm	__ __ __ . __ cm	__ __ __ . __
8.	Hip Circumference:	__ __ __ . __ cm	__ __ __ . __ cm	__ __ __ . __ cm	__ __ __ . __

* Please note, after Neck, Waist, and Hip Circumferences are calculated by the DMS write the results in the shaded area *

CHILDHOOD ADENOTONSILLECTOMY STUDY
Blood Pressure
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: ___ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

*** Please note, AVERAGE Resting Blood Pressure will be calculated by the DMS ***

1. Resting Blood Pressure 1: ___ ___ ___ / ___ ___ ___

   1a. Time collected: ___ ___ : ___ ___ (24 Hour Clock)

2. Resting Blood Pressure 2: ___ ___ ___ / ___ ___ ___

   2a. Time collected: ___ ___ : ___ ___ (24 Hour Clock)

3. Resting Blood Pressure 3: ___ ___ ___ / ___ ___ ___

   3a. Time collected: ___ ___ : ___ ___ (24 Hour Clock)

4. Average Blood Pressure: [shaded]

** After Average Blood Pressure is calculated by the DMS, please write it in the shaded area **

CHILDHOOD ADENOTONSILLECTOMY STUDY
BRIEF
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Was the form completed?
   - ☐ 0 No
   - ☐ 1 Yes

2. Who completed this form?
   - ☐ 1 Biological Parent
   - ☐ 2 Adoptive Parent
   - ☐ 3 Step Parent
   - ☐ 4 Foster Parent
   - ☐ 5 Grandparent
   - ☐ 98 Other, please specify: _____

Please provide the scores from the BRIEF questionnaire

	Scale / Index	Raw Score	T Score	Percentile
3.	Inhibit			
4.	Shift			
5.	Emotional Control			
6.	BRI			
7.	Initiate			
8.	Working Memory			
9.	Plan / Organize			
10.	Organization of Materials			
11.	Monitor			
12.	MI			
13.	GEC (BRI + MI)			

14. What is the negativity score? ___ ☐ 1 Acceptable ☐ 2 Elevated ☐ 3 Highly Elevated

15. What is the inconsistency score? ___ ☐ 1 Acceptable ☐ 2 Questionable ☐ 3 Inconsistent

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
BRIEF Teacher's Form
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

---

1. Was the Brief Teacher's Form completed and returned?
   ☐$_0$ No
   ☐$_1$ Yes

2. How well does the teacher know the child?
   ☐$_1$ Not Well
   ☐$_2$ Moderately Well
   ☐$_3$ Very Well

3. How long has the teacher known the child? __ __ Months

Please provide the scores from the BRIEF questionnaire

	Scale / Index	Raw Score	T Score	Percentile
4.	Inhibit			
5.	Shift			
6.	Emotional Control			
7.	BRI			
8.	Initiate			
9.	Working Memory			
10.	Plan / Organize			
11.	Organization of Materials			
12.	Monitor			
13.	MI			
14.	GEC (BRI + MI)			

15. What is the negativity score? __ __ ☐$_1$ Acceptable ☐$_2$ Elevated ☐$_3$ Highly Elevated

16. What is the inconsistency score? __ __ ☐$_1$ Acceptable ☐$_2$ Questionable ☐$_3$ Inconsistent

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Child Behavior Checklist
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

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1. Was the Checklist completed?

☐ 0 No
☐ 1 Yes

2. Who completed this form?

☐ 1 Biological Parent
☐ 2 Adoptive Parent
☐ 3 Step Parent
☐ 4 Foster Parent
☐ 5 Grandparent
☐ 98 Other, please specify: _____

Please provide the summary scores from the CBCL questionnaire.

		Total Score	T Score	Percentile
3.	Activities:			
4.	Social:			
5.	School:			
6.	Total Competence:			
7.	Anxious / Depressed:			
8.	Withdrawn / Depressed:			
9.	Somatic Complaints:			
10.	Social Problems:			
11.	Thought Problems:			
12.	Attention Problems:			
13.	Rule-Breaking Behavior:			
14.	Aggressive Behavior:			
15.	Internalizing Problems:			
16.	Externalizing Problems:			
17.	Total Problems:			
18.	Affective Problems:			
19.	Anxiety Problems:			
20.	Somatic Problems:			

CHILDHOOD ADENOTONSILLECTOMY STUDY
Child Behavior Checklist
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

		Total Score	T Score	Percentile
21.	Attention Deficit / Hyperactivity Problems:			
22.	Oppositional Defiant Problems:			
23.	Conduct Problems:			

CHILDHOOD ADENOTONSILLECTOMY STUDY
Child Depression Inventory
Age 7 and up
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Was this test performed?
   - ☐ 0 No
   - ☐ 1 Yes

   1a. If NO, please provide a reason:
   - ☐ 1 Child is not of Age
   - ☐ 2 Other, specify: _____

2. Was any assistance given to the child during the administration of this test?
   - ☐ 0 No
   - ☐ 1 Yes

3. Did the child endorse a score of "3" on Item 9?
   - ☐ 0 No
   - ☐ 1 Yes

Please provide the Total Scores and T-Scores from the CDI

		Total Score	T-Score
4.	Total CDI Score:		
5.	Scale A: Negative Mood		
6.	Scale B: Interpersonal Problems		
7.	Scale C: Ineffectiveness		
8.	Scale D: Anhedonia		
9.	Scale E: Negative Self-Esteem		

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Child Demographic Information
BASELINE

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

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1. What is your child's Date of Birth? __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

   1a. What is your child's age? __ __ Years __ __ Months

2. What is your child's gender? ☐1 Male ☐2 Female

3. What is your child's ethnicity?
   ☐1 Hispanic or Latino
   ☐2 Not Hispanic or Latino

4. What is your child's race?
   ☐1 American Indian / Native Alaskan
   ☐2 Asian
   ☐3 Native Hawaiian / Other Pacific Islander
   ☐4 Black / African American
   ☐5 White / Caucasian
   ☐6 Multiracial
   ☐98 Other, specify: _____

5. What is your child's current or most recently completed grade in school?
   __ __ Grade
   ☐99 Not attending

   5a. If your child is not attending, please provide a reason:
   ☐1 Summer Vacation
   ☐2 Child is home schooled
   ☐3 Other, specify: _____

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
PedsQL – Child Report (ages 5-7)
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

Directions:
This form should be read to the child (ages 5 – 7), use the template attached to this CRF (also included in the MOP), which has the smiley face icons as reference for each of the three possible answers – Not at all, Sometimes, and A lot.

Say to the child: **Think about how you have been doing for the last few weeks. Please listen carefully to each sentence and tell me how much of a problem this is for you.**

After reading each item below, gesture to the smiley face template. If the child hesitates or does not seem to understand how to answer, read the response options while pointing at the smiley face icons.

1.	Physical Functioning (problems with):	Not at all	Sometimes	A lot
1a.	Is it hard for you to walk?	☐0	☐2	☐4
1b.	Is it hard for you to run?	☐0	☐2	☐4
1c.	Is it hard for you to play sports or exercise?	☐0	☐2	☐4
1d.	Is it hard for you to pick up big things?	☐0	☐2	☐4
1e.	Is it hard for you to take a bath or shower?	☐0	☐2	☐4
1f.	Is it hard for you to do chores (like pick up your toys)?	☐0	☐2	☐4
1g.	Do you have hurts or aches (Where _____)?	☐0	☐2	☐4
1h.	Do you ever feel too tired to play?	☐0	☐2	☐4

2.	Emotional Functioning (problems with):	Not at all	Sometimes	A lot
2a.	Do you feel scared?	☐0	☐2	☐4
2b.	Do you feel sad?	☐0	☐2	☐4
2c.	Do you feel mad?	☐0	☐2	☐4
2d.	Do you have trouble sleeping?	☐0	☐2	☐4
2e.	Do you worry about what will happen to you?	☐0	☐2	☐4

3.	Social Functioning (problems with):	Not at all	Sometimes	A lot
3a.	Is it hard for you to get along with other kids?	☐0	☐2	☐4
3b.	Do other kids say they do not want to play with you?	☐0	☐2	☐4
3c.	Do other kids tease you?	☐0	☐2	☐4
3d.	Can other kids do things that you cannot?	☐0	☐2	☐4
3e.	Is it hard for you to keep up when you play with other kids?	☐0	☐2	☐4

4.	School Functioning (problems with):	Not at all	Sometimes	A lot
4a.	Is it hard for you to pay attention in school?	☐0	☐2	☐4
4b.	Do you forget things?	☐0	☐2	☐4
4c.	Is it hard to keep up with schoolwork?	☐0	☐2	☐4
4d.	Do you miss school because of not feeling good?	☐0	☐2	☐4
4e.	Do you miss school because you have to go to the doctor's or hospital?	☐0	☐2	☐4

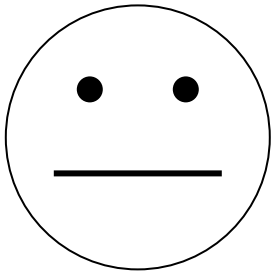
Childhood Adenotonsillectomy Study
PedsQL – Child Report (ages 5-7)
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

How much of a problem is this for you?

Not at all

Sometimes



A lot

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
PedsQL – Child Report (ages 8 – 12)
Visit __ __

[Child Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

Directions: The following is a list of things that might be a problem for you. Please tell us **how much of a problem** each one has been for you during the **past ONE month** by checking the box. There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past **ONE month**, how much of a **problem** has this been for you…

1.	About My Health and Activities (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
1a.	It is hard for me to walk more than one block	☐0	☐1	☐2	☐3	☐4
1b.	It is hard for me to run	☐0	☐1	☐2	☐3	☐4
1c.	It is hard for me to do sports activity or exercise	☐0	☐1	☐2	☐3	☐4
1d.	It is hard for me to lift something heavy	☐0	☐1	☐2	☐3	☐4
1e.	It is hard for me to take a bath or shower by myself	☐0	☐1	☐2	☐3	☐4
1f.	It is hard for me to do chores around the house	☐0	☐1	☐2	☐3	☐4
1g.	I hurt or ache	☐0	☐1	☐2	☐3	☐4
1h.	I have low energy	☐0	☐1	☐2	☐3	☐4

2.	About My Feelings (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
2a.	I feel afraid or scared	☐0	☐1	☐2	☐3	☐4
2b.	I feel sad or blue	☐0	☐1	☐2	☐3	☐4
2c.	I feel angry	☐0	☐1	☐2	☐3	☐4
2d.	I have trouble sleeping	☐0	☐1	☐2	☐3	☐4
2e.	I worry about what will happen to me	☐0	☐1	☐2	☐3	☐4

3.	How I Get Along With Others (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
3a.	I have trouble getting along with other kids	☐0	☐1	☐2	☐3	☐4
3b.	Other kids do not want to be my friend	☐0	☐1	☐2	☐3	☐4
3c.	Other kids tease me	☐0	☐1	☐2	☐3	☐4
3d.	I cannot do things that other kids my age can do	☐0	☐1	☐2	☐3	☐4
3e.	It is hard to keep up when I play with other kids	☐0	☐1	☐2	☐3	☐4

4.	About School (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
4a.	It is hard to pay attention in class	☐0	☐1	☐2	☐3	☐4
4b.	I forget things	☐0	☐1	☐2	☐3	☐4
4c.	I have trouble keeping up with my schoolwork	☐0	☐1	☐2	☐3	☐4
4d.	I miss school because of not feeling well	☐0	☐1	☐2	☐3	☐4
4e.	I miss school to go to the doctor or hospital	☐0	☐1	☐2	☐3	☐4

CHILDHOOD ADENOTONSILLECTOMY STUDY
Concominant Medications

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __

#	Drug Code	Medication Name	Start Dates	Stop Dates Check box if medication is continuing.	Total Daily Dose	Unit 1 = mg, 2 = mcg, 3 = tablets, 4 = ml/cc, 5 = tsp, 6 = tbsp, 7 = oz, 8 = drops, 9 = spray, 10 = units, 98 = Other	Frequency 1 = qd, 2 = bid, 3 = tid, 4 = qid, 5 = PRN, 98 = Other	Route 1 = Oral, 2 = IV, 3 = IM, 4 = SC, 5 = Topical, 6 = Rectal, 7 = Nasal, 8 = Transdermal, 9 = Inhalant, 10 = Sublingual, 98 = Other
				☐				
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CHILDHOOD ADENOTONSILLECTOMY STUDY
Conners' Parent Rating Scale
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Was the questionnaire given to the parent / guardian? ☐0 No ☐1 Yes

Please provide the summary scores from the Conners' questionnaire.

		Raw Score	T-Score
2.	Oppositional:		
3.	Cognitive Problems / Inattention:		
4.	Hyperactivity:		
5.	Anxious / Shy:		
6.	Perfectionism:		
7.	Social Problems:		
8.	Psychosomatic:		
9.	Conners' ADHD Index:		
10.	Conners' GI Restless – Impulsive:		
11.	Conners' GI Emotional Liability:		
12.	Conners' GI Total		
13.	DSM-IV Inattentive:		
14.	DSM-IV Hyperactive-Impulsive:		
15.	DSM-IV Total:		
16.	Inattentive Symptoms:		
17.	Hyperactive-Impulsive Symptoms:		

CHILDHOOD ADENOTONSILLECTOMY STUDY
Conners' Teacher's Rating Scale
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Was the Conners' Teacher's form completed and returned?
   ☐ 0 No
   ☐ 1 Yes

2. How well does the teacher know the child?
   ☐ 1 Not Well
   ☐ 2 Moderately Well
   ☐ 3 Very Well

3. How long has the teacher known the child? __ __ Months

Please provide the summary scores from the Conners' Teacher's questionnaire.

		Raw Score	T-Score
4.	Oppositional:		
5.	Cognitive Problems / Inattention:		
6.	Hyperactivity:		
7.	Anxious / Shy:		
8.	Perfectionism:		
9.	Social Problems:		
10.	Conners' ADHD Index:		
11.	Conners' GI Restless – Impulsive:		
12.	Conners' GI Emotional Liability:		
13.	Conners' GI Total		
14.	DSM-IV Inattentive:		
15.	DSM-IV Hyperactive-Impulsive:		
16.	DSM-IV Total:		
17.	Inattentive Symptoms:		
18.	Hyperactive-Impulsive Symptoms:		

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Differential Ability Scales (DAS-II)
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Was the DAS-II administered? ☐$_0$ No ☐$_1$ Yes

2. What is the child's level? ☐$_1$ School-Age Level (Ages 7.0 – 17.11) ☐$_2$ Out-of-Level (Ages 5.0 – 6.11)

3. What is the child's handedness? ☐$_1$ Right ☐$_2$ Left ☐$_3$ Both

	Core Subtest T-Scores	Ability Score	T-Score	Verbal	Nonverbal Reasoning	Spatial	GCA	SNC	Percentile
4.	Recall of Designs								
5.	Word Definitions								
6.	Pattern Construction ☐$_1$ Std. ☐$_2$ Alt.								
7.	Matrices								
8.	Verbal Similarities								
9.	Sequential & Quantitative Reasoning								

	Cluster / Composite Scores	Verbal	Nonverbal Reasoning	Spatial	GCA	SNC
10.	Sum of Core Subtest T-Scores					
11.	Standard Score					
12.	Percentile					

CHILDHOOD ADENOTONSILLECTOMY STUDY
Protocol Defined Eligibility
BASELINE

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

Inclusion Criteria:
(Responses to questions 1 – 4 must be "YES" or "Not Applicable" to meet eligibility requirements)

1. Is the participant between the ages of 5.0 to 9.99? ☐1 Yes ☐0 No

2. Does the participant have obstructive sleep apnea defined as: ☐1 Yes ☐0 No
   a. Obstructive apnea index OAI ≥ 1 or Apnea hyponea index AHI ≥ 2, confirmed on nocturnal, laboratory-based PSG and
   b. Parental report of habitual snoring (on average occurring > 3 nights per week).

3. Does the participant have Tonsillar hypertrophy ≥ 2 based on a standardized 0-4 scale:

3a. Does the participant have Tonsillar hypertrophy ≥ 1 based on a standardized 0-4 scale: ☐1 Yes ☐0 No
   a. 0 = Surgically absent
   b. 1 = Taking up < 25% of the airway
   c. 2 = 25 – 50% of the airway
   d. 3 = 50-75% of the airway
   e. 4 = > 75% of the airway

4. Has the participant been deemed to be a surgical candidate for AT by ENT evaluation? ☐1 Yes ☐0 No

Exclusion Criteria:
(Responses to questions 5 – 21 must be "No" or "Not Applicable" to meet eligibility requirements)

5. Has the participant had recurrent tonsillitis that meets published ENT clinical practice guidelines for surgery defined as ≥ 3 episodes in each of 3 years, 5 episodes in each of 2 years, or 7 episodes in 1 year? ☐1 Yes ☐0 No

6. Does the participant have craniofacial anomalies, including cleft lip and palate or sub-mucosal palate le or any anatomic or systemic condition which would interfere with general anesthesia or removal of tonsils and adenoid tissue in the standard fashion? ☐1 Yes ☐0 No

7. Does the participant have obstructive breathing while awake that merits prompt AT in the opinion of the child's physician? ☐1 Yes ☐0 No

8. Does the participant have severe OSAS and significant hypoxemia requiring immediate AT as defined by: ☐1 Yes ☐0 No
   a. OAI > 20 or
   b. AHI > 30,
   c. Desaturation defined as SaO_2 < 90% for more than 2% sleep time

9. Does the participant have apnea hypopnea indices in the normal range (OAI < 1 and AHI < 2)? ☐1 Yes ☐0 No

10. Does the participant exhibit evidence of clinically significant cardiac Arrhythmia on PSG: ☐1 Yes ☐0 No
    a. Non-sustained ventricular tachycardia
    b. Atrial fibrillation
    c. Second degree AV block
    d. Sustained bradycardia < 40 bpm (> 2 minutes)
    e. Sustained tachycardia > 140 bpm (> 2 minutes)

11. Is the participant extremely overweight defined as: BMI > 2.5 for age group and sex-z score?

11a. Is the participant extremely overweight defined as: BMI > 2.99 for age group and sex-z score? ☐1 Yes ☐0 No

12. Does the participant have severe health problems that could be exacerbated by delayed treatment for OSAS including: ☐1 Yes ☐0 No
    a. Doctor-diagnosed heart disease or cor pulmonale
    b. Stage II hypertension as defined > 99% percentile (CDC) plus 5 mmHg for either systolic or diastolic examination, based on the age, gender, and height norms, as measured on the baseline exam, or the PSG, or requiring medication
    c. Therapy for failure to thrive or short stature
    d. Psychiatric or behavioral disorders requiring or likely to require initiation of new medication, therapy, or other specific treatment during the 12 month trial period
    e. For school aged children, parental report of excessive daytime sleepiness defined as unable to maintain wakefulness, at least three times per week, in routine activities in school or home, despite adequate opportunity to sleep.

13. Does the participant have severe chronic health conditions that might hamper participation, including: ☐1 Yes ☐0 No
    a. Severe cardiopulmonary disorders (e.g.: cystic fibrosis, congenital heart disease)
    b. Sickle cell anemia
    c. Poorly controlled asthma (with > 1 hospitalization in last year)
    d. Epilepsy requiring medication
    e. Diabetes (type I or type II) requiring medication
    f. Conditions likely to preclude accurate polysomnography (e.g.: severe uncontrolled pain)
    g. Mental retardation or enrollment in a formal school Individual Educational Plan (IEP) and assigned to a self-contained classroom for all academic subjects
    h. History of inability to complete cognitive testing and / or score on DASII of ≤55
    i. Chronic infection or HIV

14. Does the participant have known genetic, craniofacial, neurological or psychiatric conditions likely to affect the airway, cognition, or behavior? ☐1 Yes ☐0 No

15. Does the participant currently use any of the following medications: ☐1 Yes ☐0 No
    a. ADHD medications
    b. Psychotropic medication (antidepressants, anxiolytics, antipsychotics)
    c. Hypnotics
    d. Hypoglycemic agents or insulin
    e. Antihypertensives
    f. Growth Hormone
    g. Anticonvulsants
    h. Anti-coagulants
    i. Daily oral corticosteroids
    j. Daily medications for pain

16. Has the participant had previous upper airway surgery on the nose, pharynx or larynx, including adenoidectomy. (Ear surgery – e.g.: PE tubes – is not an exclusion criterion).

16a. Has the participant had previous upper airway surgery on the nose, pharynx or larynx, including tonsillectomy (PE Tubes or prior adenoidectomy are not exclusion criteria)? ☐1 Yes ☐0 No

17. Has the participant received Continuous Positive Airway Pressure (CPAP) treatment? ☐1 Yes ☐0 No

18. Does the participant have a parent or guardian who cannot accompany the child on the night of PSG? ☐1 Yes ☐0 No

19. Does the participant have a parent or guardian who cannot read and understand the consent form; including families unable to understand or complete the standardized English language assessment forms and testing instruments?

20. Does the child belong to a family planning to move out of the area within the year? ☐1 Yes ☐0 No

21. For female participants, has the participant attained menarche by the time of study enrollment per parental report? ☐1 Yes ☐0 No ☐99 Not Applicable

Eligibility Confirmation:

22. Are all of the Inclusion Criteria responses “Yes”? ☐1 Yes ☐0 No
If No, STOP. Participant is not eligible.

23. Are all of the exclusion Criteria responses “No” or “Not Applicable”? ☐1 Yes ☐0 No
If No, STOP. Participant is not eligible.

CHILDHOOD ADENOTONSILLECTOMY STUDY
Family History
BASELINE

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Did your child's biological mother smoke at least one cigarette a day while she was pregnant with your child?
   ☐0 No
   ☐1 Yes (1+ per day)
   ☐88 Not sure

   1a. Does your child's current primary caregiver smoke at least one cigarette a day?
   ☐0 No
   ☐1 Yes (1+ per day)
   ☐88 Not sure

2. How many people currently smoke at least one cigarette a day in your child's home? __ __

Brother and Sister History:

3. Does your child have any full brothers and / or sisters (same mother and father as child)?
   ☐0 No
   ☐1 Yes
   ☐88 Not sure

   3a. If YES, how many FULL sisters? __ __

   3b. If YES, how many FULL brothers? __ __

4. Does your child have any half brothers and / or sisters (one parent in common with child)?
   ☐0 No
   ☐1 Yes
   ☐88 Not sure

   4a. If YES, how many HALF sisters? __ __

   4b. If YES, how many HALF brothers? __ __

5. Do any of your child's brothers and / or sisters have any of the following conditions?
   ☐99 Not applicable / No Brothers or Sisters

	Conditions	No / Yes	*If Yes, please indicate who has the condition.* Full Brothers / Sisters	Half Brothers / Sisters
5a.	Acute Life Threatening Episode (ALTE)	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5b.	Crib death or Sudden Infant Death Syndrome (SIDS)	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)

CHILDHOOD ADENOTONSILLECTOMY STUDY
Family History
BASELINE

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

	Conditions	No / Yes	*If Yes, please indicate who has the condition.* Full Brothers / Sisters	Half Brothers / Sisters
5c.	Anxiety Disorder	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5d.	Asthma	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5e.	Attention Deficit Hyperactivity Disorder (ADD / ADHD)	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5f.	Cancer	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5g.	Cerebral Palsy	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5h.	Depression	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5i.	Diabetes	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5j.	Eating Disorder (Anorexia, Bulimia)	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5k.	Eczema (Atopic Dermatitis)	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)

	Conditions	No / Yes	*If Yes, please indicate who has the condition.* Full Brothers / Sisters	Half Brothers / Sisters
5l.	Enlarged Tonsils or Adenoids	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5m.	Excessive Sleepiness (3 or more times per week)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5n.	Hay Fever (Nasal Allergies)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5o.	High Blood Pressure (Hypertension)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5p.	High Cholesterol	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5q.	Insomnia	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5r.	Loud Snoring (3 or more times per week)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5s.	Migraine Headache or Chronic Severe Headache	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5t.	Narcolepsy	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)
5u.	Sleep Apnea	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)	__ __ ☐$_1$ Sister(s) __ __ ☐$_2$ Brother(s)

	Conditions	No / Yes	*If Yes, please indicate who has the condition.* Full Brothers / Sisters	Half Brothers / Sisters
5v.	Autism	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5w.	Aspergers Syndrome	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)
5x.	Other Significant Medical Conditions: _____ _____ _____	☐0 No ☐1 Yes ☐88 Not Sure	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)	__ __ ☐1 Sister(s) __ __ ☐2 Brother(s)

Parental History:

6. Has either biological parent currently or ever had any of the following conditions?

☐99 Not Applicable / Information not available

	Conditions	No / Yes	*If Yes, please indicate which parent had the condition.* Biological Mother	Biological Father
6a.	Anxiety Disorder	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes
6b.	Asthma	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes
6c.	Attention Deficit Hyperactivity Disorder (ADD / ADHD)	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes
6d.	Cancer	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes
6e.	Depression	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes

	Conditions	No / Yes	*If Yes, please indicate which parent had the condition.* Biological Mother	Biological Father
6f.	Diabetes	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6g.	Eczema	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6h.	Enlarged Tonsils or Adenoids	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6i.	Excessive Sleepiness (3 or more times per week)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6j.	Hay Fever (Nasal Allergies)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6k.	High Blood Pressure (Hypertension)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6l.	High Cholesterol	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6m.	Heart Disease	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6n.	Insomnia	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6o.	Loud Snoring (3 or more times per week)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6p.	Migraine Headache or Chronic Severe Headache	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes
6q.	Narcolepsy	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes	☐$_0$ No ☐$_1$ Yes

	Conditions	No / Yes	If Yes, please indicate which parent had the condition. Biological Mother	Biological Father
6r.	Sleep Apnea	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes
6s.	Emphysema or Chronic Obstructive Lung Disease	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes
6t.	Other Significant Medical Conditions: _____ _____ _____	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes	☐0 No ☐1 Yes

7. What was the mother's height at the time of your child's birth? __ __ . __ __ feet / inches ☐88 Not Sure

8. What was the mother's weight at the time of your child's birth? __ __ __ . __ lbs / oz ☐88 Not Sure

9. What is the mother's current height? __ __ . __ __ feet / inches ☐88 Not Sure

10. What is the mother's current weight? __ __ __ . __ lbs / oz ☐88 Not Sure

Child's Respiratory History:

11. In the PAST YEAR, did your child:

		No	Yes	Not Sure
11a.	Usually have a cough?	☐0	☐1	☐88

		No	Yes	Not Sure	
11b.	Usually cough on most days for three (3) consecutive months or more?	☐0	☐1	☐88	
11c.	Usually bring up phlegm from the chest?	☐0	☐1	☐88	
11d.	Bring up phlegm as much as twice a day, four or more times a week, for three (3) consecutive months or more?	☐0	☐1	☐88	
11e.	Usually bring up phlegm at all on getting up or first thing in the morning?	☐0	☐1	☐88	
11f.	Have periods or episodes of increased cough and phlegm lasting three (3) weeks or more?	☐0	☐1	☐88	
11g.	Have an attack of wheezing that made him or her feel short of breath?	☐0	☐1	☐88	***If Yes, please answer the following:***
11h.	Been troubled by shortness of breath when hurrying on level ground or walking up a slight hill?	☐0	☐1	☐88	☐1 Rarely ☐2 Sometimes ☐3 Often ☐4 Almost Daily
11i.	Been troubled by chest tightness?	☐0	☐1	☐88	☐1 Rarely ☐2 Sometimes ☐3 Often ☐4 Almost Daily

12. In the PAST Year, has your child's chest sounded wheezy or whistling?

☐0 No
☐1 Yes
☐88 Not Sure

		If Yes, please answer the following:		
		No	**Yes**	**Not Sure**
12a.	When your child has a cold?	☐0	☐1	☐88
12b.	Occasionally apart from colds?	☐0	☐1	☐88
12c.	Most days or nights?	☐0	☐1	☐88

		If Yes to Question 12, please answer the following:		
		No	**Yes**	**Not Sure**
12d.	With exercise?	☐0	☐1	☐88
12e.	Only during the night?	☐0	☐1	☐88
12f.	With exposure to dust or fumes?	☐0	☐1	☐88
12g.	When exposed to pollen?	☐0	☐1	☐88

13. In the PAST YEAR, did any of the following situations cause your child to have a stuffy or runny nose?

		No	**Yes**	**Not Sure**
13a.	A Smoky Room	☐0	☐1	☐88
13b.	A Dusty Room	☐0	☐1	☐88
13c.	Cold Weather	☐0	☐1	☐88
13d.	Exercise	☐0	☐1	☐88

CHILDHOOD ADENOTONSILLECTOMY STUDY
Fasting Venipuncture Form
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

Note – A copy of this form must be submitted to the Vermont Labs with the specimen.

Collection Information:

1. Draw time: ____ : ____ (24 Hour Clock)

2. Does the participant bleed or bruise easily?
   ☐ 0 No
   ☐ 1 Yes
   ☐ 88 Don't Know

3. Has the participant ever been told that they have a disorder related to blood clotting or coagulation?
   ☐ 0 No
   ☐ 1 Yes
   ☐ 88 Don't Know

4. Has the participant ever experienced fainting spells while having blood drawn?
   ☐ 0 No
   ☐ 1 Yes
   ☐ 88 Don't Know

5. Time at start of venipuncture: ____ : ____ (24 Hour Clock)

6. Elapsed time until tourniquet released: ____ : ____ (24 Hour Clock)

7. Time at end of venipuncture: ____ : ____ (24 Hour Clock)

8. Was any blood drawn?
   ☐ 1 Yes, full sample
   ☐ 2 Yes, partial sample
   ☐ 3 No, refused
   ☐ 4 No, hard to stick
   ☐ 98 No, other reason, specify:
   _____
   _____

   8a. If Partial Sample was obtained, please specify:
   10 mL Serum Partial Volume __ __
   10 mL EDTA Partial Volume __ __
   Note if either of these were not done, write ND in space provided.

9. Quality of venipuncture:
   ☐ 1 Traumatic
   ☐ 2 Clean

   9a. If Quality is Traumatic, please check all that apply:
   ☐ 1 Vein collapse
   ☐ 2 Hematoma
   ☐ 3 Excessive duration of draw
   ☐ 4 Vein hard to get
   ☐ 5 Leakage at venipuncture site
   ☐ 6 Multiple stick

CHILDHOOD ADENOTONSILLECTOMY STUDY
Fasting Venipuncture Form
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

Processing Information:

10. Processing Start Time: ____ : ____ EDTA (24 Hour Clock) __ __ : ____ SERUM (24 Hour Clock)

11. Vial processing information:

	Vial #	Type	Color	Vol. (mL)	Done	Comments
11a.	1	SERUM	Clear	1.0mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11b.	2	SERUM	Red	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11c.	3	SERUM	Red	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11d.	4	SERUM	RED	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11e.	5	SERUM	RED	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11f.	6	SERUM	RED	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11g.	7	SERUM	RED	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11h.	8	SERUM	RED	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11i.	9	SERUM	RED	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11j.	10	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11k.	11	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11l	12	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11m.	13	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11n.	14	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11o.	15	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11p.	16	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11q.	17	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11r.	18	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11s.	19	EDTA	PURPLE	0.5mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis
11t.	20	Packed Cells	WHITE	5.0mL	☐0 No ☐1 Yes	☐1 Partial Volume ☐2 Hemolysis

12. Were samples frozen? ☐0 No ☐1 Yes

13. Date samples sent to Vermont Lab: __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)

CHILDHOOD ADENOTONSILLECTOMY STUDY
Materials Provided
Baseline Visit

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Were educational materials provided to the child?
   ☐0 No
   ☐1 Yes

2. Was Nasal Saline Spray provided to the child?
   ☐0 No
   ☐1 Yes

   2a. If Yes, what was the lot number?
   __ __ __ __

   2b. Were directions and application uses reviewed with the parent or guardian?
   ☐0 No
   ☐1 Yes

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Medical History
BASELINE

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Has your child ever been diagnosed by a doctor with any of the following?

			If YES to "Ever had this condition", answer these questions:		
	Conditions	**Ever had this condition?**	**Diagnosed or treated by a physician?**	**Still Present?**	**Currently taking medication for this condition?**
1a.	Acute Life Threatening Episode (ALTE)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1b.	Anxiety Disorder	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1c.	Asthma	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1d.	Attention Deficit Hyperactivity Disorder (ADD / ADHD)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1e.	Cancer	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1f.	Cerebral Palsy	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1g.	Heartburn or acid reflux	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1h.	Depression	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1i.	Diabetes	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1j.	Eating Disorder (Anorexia, Bulimia)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1k.	Eczema (Atopic Dermatitis)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure
1l.	Hay Fever (Nasal Allergies)	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure	☐$_0$ No ☐$_1$ Yes ☐$_{88}$ Not Sure

CHILDHOOD ADENOTONSILLECTOMY STUDY
Medical History
BASELINE

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

	Conditions	Ever had this condition?	*If YES to "Ever had this condition", answer these questions:* Diagnosed or treated by a physician?	Still Present?	Currently taking medication for this condition?
1m.	High Blood Pressure (Hypertension)	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure
1n.	High Cholesterol	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure
1o.	Insomnia	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure
1p.	Migraine Headache or Chronic Severe Headache	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure
1q.	Autism	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure
1r.	Aspergers Syndrome	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure
1s.	Other Significant Medical Conditions: _____ _____ _____ _____	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure	☐0 No ☐1 Yes ☐88 Not Sure

2. Does your child have allergies?
☐0 No
☐1 Yes

2a. If Yes, has your child ever been tested (skin or blood) for allergies?
☐0 No
☐1 Yes
☐88 Not Sure

2b. If Yes, which of the following tests were positive for allergies (check all that apply):

☐1 Molds ☐2 Trees ☐3 Cats ☐4 Insects
☐5 Dust ☐6 Grass or Pollen ☐7 Dogs ☐8 Food / Drink
☐9 Latex ☐98 Other, specify: _____

3. Has your child ever had Surgery requiring an over night stay?

☐0 No
☐1 Yes

	Surgery	Date Performed
3a.	Please specify: _____	__ __ / __ __ / __ __ __ __
3b.	Please specify: _____	__ __ / __ __ / __ __ __ __
3c.	Please specify: _____	__ __ / __ __ / __ __ __ __
3d.	Please specify: _____	__ __ / __ __ / __ __ __ __

4. Has your child ever been referred to any of the following specialists?

		NO	YES
4a.	Cardiologist (Heart Doctor)	☐0	☐1
4b.	Gastroenterologist (Stomach Doctor)	☐0	☐1
4c.	Pulmonologist (Lung Doctor)	☐0	☐1
4d.	Neurologist	☐0	☐1
4e.	Otolarynologist (Ear, Nose, & Throat Doctor)	☐0	☐1
4f.	Psychiatrist / Psychologist	☐0	☐1
4g.	Sleep Specialist	☐0	☐1

5. What was your child's weight at birth?

__ __ __ . __ __ lbs / oz
☐99 Not Sure

6. Was your child born early (prematurely, or 4 or more weeks early)?

☐0 No
☐1 Yes
☐88 Not Sure

7. Did your child need oxygen for more than one day after birth?

☐0 No
☐1 Yes
☐88 Not Sure

CHILDHOOD ADENOTONSILLECTOMY STUDY
NEPSY
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Were any sections of the NEPSY performed?

☐ 0 No
☐ 1 Yes

2. Please indicate the child's hand preference:

☐ 1 Right
☐ 2 Left
☐ 3 Ambidextrous
☐ 88 Not Established

Please provide the summary scores from the NEPSY for the appropriate subtest

	Subtest	***Raw Score***	***Attn / Exec Scaled Scores***	***Language Scaled Scores***
3.	Phonological Processing			
4.	Tower			
5.	Auditory Attention and Response Set			
6.	Speeded Naming			
7.	Visual Attention			
8.	Comprehension of Instructions			
9.	Sum Scaled Scores			
10.	Core Domain Scores			
11.	Percentile			

** NOTE: For V8, only complete Attn / Exec scores. Please write in ND for the remaining columns for V8. **

12. Please provide the scores for the Arrows sub-section:

__ __ __ Raw Score

__ __ __ Scaled Score

CHILDHOOD ADENOTONSILLECTOMY STUDY
NEPSY-II Inhibition Scores
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Were any sections of the NEPSY-II Inhibition subtest performed? ☐$_0$ No ☐$_1$ Yes

2.	***Inhibition Naming***	***Score***
2a.	Inhibition Naming Total Errors Percentile Rank:	
2b.	Inhibition Naming Total Completion Time Scaled Score:	
2c.	Inhibition Naming Combined Scaled Score:	

3.	***Inhibition – Inhibition***	***Score***
3a.	Inhibition – Inhibition Total Errors Percentile Rank:	
3b.	Inhibition – Inhibition Total Completion Time Scaled Score:	
3c.	Inhibition – Inhibition Combined Scaled Score:	

4.	***Inhibition Switching:***	***Score***
4a.	Inhibition – Switching Total Errors Percentile Rank:	
4b.	Inhibition – Switching Completion Time Scaled Score:	
4c.	Inhibition – Switching Combined Scaled Score:	

5.	***Inhibition Contrast:***	***Score***
5a.	Inhibition Naming vs. Inhibition – Inhibition Contrast Scaled Score::	
5b.	Inhibition – Inhibition vs. Inhibition – Switching Contrast Scaled Score:	

6. Inhibition Total Error Scaled Score: _____

CHILDHOOD ADENOTONSILLECTOMY STUDY
NEPSY-II Word Generation Scores
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Were any sections of the NEPSY-II Word Generation subtest performed? ☐$_0$ No ☐$_1$ Yes

Please provide the scores for the following NEPSY-II Word Generation Subtest Items:

2. Word Generation Semantic Total Score: _____
3. Word Generation Semantic Scaled Score: _____
4. Word Generation Initial Letter Total Score: _____
5. Word Generation Initial Letter Scaled Score: _____
6. Word Generation Semantic vs. Initial Letter Contrast Scaled Score: _____

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Neuropsychological Test Validity Form
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

Please rate each test / questionnaire given for their validity

	Test / Questionnaire Name	Child	Parent	Teacher
1.	Beery VMI (VMI)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
2.	DAS - II (DAS2)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
3.	NEPSY (NEPSY)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
4.	NEPSY – II Inhibition Scores (NEPSY2)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
5.	NEPSY – II Word Generation Subtest (NEPWRD)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
6.	WRAML-2 (WRAML2)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
7.	Purdue Pegboard (PUPEG)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
8.	CDI (CDI)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done		
9.	Conners' Parent (CONN)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done	
10.	Conners' Teacher (CONNTR)			☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done
11.	BRIEF Parent (BRIEF)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done	
12.	BRIEF Teacher (BRITR)			☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done

CHILDHOOD ADENOTONSILLECTOMY STUDY
Neuropsychological Test Validity Form
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

	Test / Questionnaire Name	Child	Parent	Teacher
13.	Child Behavior Checklist (CBCL)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done	
14.	Pediatric Sleep Questionnaire (PSLQ)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done	
15.	Modified Epworth Sleepiness Scale (SLSC)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done	
16.	PedsQL – Child Report (ages 5-7) (CHQL1)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done / Not Applicable		
17.	PedsQL – Child Report (ages 8-12) (CHQL2)	☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done / Not Applicable		
18.	PedsQL – Parent Report (ages 5-7) (PAQL1)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done / Not Applicable	
19.	PedsQL – Parent Report (ages 8-12) (PAQL2)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done / Not Applicable	
20.	OSA-18 Quality of Life (OSAS)		☐$_1$ Valid ☐$_2$ Questionable ☐$_{99}$ Not Done	

Comments: _____

_____

_____

_____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Intra Operative Data Sheet
Visit __ __

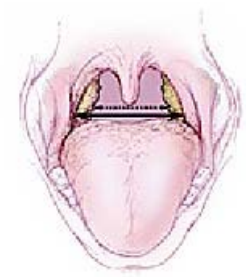
Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

---

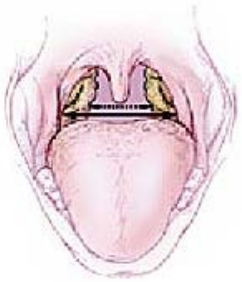
1. Please provide the Surgeon ID: __ __ - __ __

2. What was the pre-operation Adenoid size?
   ☐1 0 – 32% of nasopharynx occluded
   ☐2 33 – 66% of nasopharynx occluded
   ☐3 67 – 100% of nasopharynx occluded

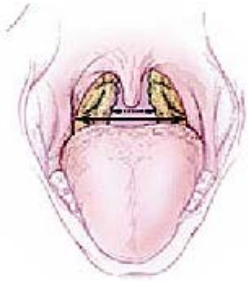
3. What was the pre-operation Tonsil size?
   (Please refer to the photos below)



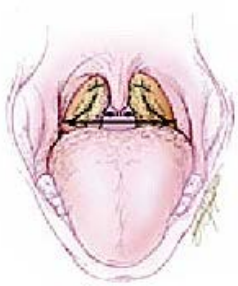
☐1 1+ 0 – 25%



☐2 2+ 26 – 50%



☐3 3+ 51 – 75%



☐4 4+ 76 – 100%

4. What surgical technique was used for Adenoid removal?
   ☐1 Cautery
   ☐2 Cold dissection
   ☐3 Adenoids not removed
   ☐98 Other, specify: _____

   4a. Were adenoids previously removed? ☐0 No ☐1 Yes

5. What surgical technique was used for Tonsil removal?
   ☐1 Cautery
   ☐2 Cold dissection
   ☐98 Other, specify: _____

6. What was the EBL?
   ☐1 <100 cc
   ☐98 Other (__ __ __ __ cc)

7. What was the post-operation Adenoid size?
   ☐1 0 – 32% of nasopharynx occluded
   ☐2 33 – 66% of nasopharynx occluded
   ☐3 67 – 100% of nasopharynx occluded

8. Were the tonsils removed completely? ☐0 No ☐1 Yes

CHILDHOOD ADENOTONSILLECTOMY STUDY
Intra Operative Data Sheet
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

9. Were digital photos done? ☐0 No ☐1 Yes

9a. If YES, was the digital photo sent to the Surgical QC group? ☐0 No ☐1 Yes

9b. If digital photo was sent, what was the file name? _____

10. Were there any complications with the surgical procedure? ☐0 No ☐1 Yes

10a. If Yes, please check all that apply:

☐1 Damage to teeth
☐2 Burns to soft tissue
☐3 Airway fire*****
☐4 Excessive blood loss (>250 cc)
☐5 Need for blood transfusion
☐6 Return to OR (control hemorrhage)*****
☐7 Re-intubation requiring unanticipated ICU admission*****
☐8 Death*****
☐98 Other (including atlanto-axial subluxation with neurological deficit*****, foreign body aspiration*****), specify: _____

_____

_____

**** Serious Adverse Event, requires immediate action as outlined in the MOP ****

OSA-18 Quality of Life Survey
Evaluation of Sleep-Disordered Breathing

Instructions. For each question below, please circle the number that best describes how often each symptom or problem has occurred during the past *4 weeks* (or since the last survey if sooner). Thank you.

	None of the time	Hardly any of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
SLEEP DISTURBANCE							
During the past *4 weeks*, how often has your child had…							
…loud snoring?	1	2	3	4	5	6	7
…breath holding spells or pauses in breathing at night?	1	2	3	4	5	6	7
…choking or gasping sounds while asleep?	1	2	3	4	5	6	7
…restless sleep or frequent awakenings from sleep?	1	2	3	4	5	6	7
PHYSICAL SUFFERING							
During the past *4 weeks*, how often has your child had…							
…mouth breathing because of nasal obstruction?	1	2	3	4	5	6	7
…frequent colds or upper respiratory infections?	1	2	3	4	5	6	7
…nasal discharge or runny nose?	1	2	3	4	5	6	7
…difficulty in swallowing foods?	1	2	3	4	5	6	7
EMOTIONAL DISTRESS							
During the past *4 weeks*, how often has your child had…							
…mood swings or temper tantrums?	1	2	3	4	5	6	7
…aggressive or hyperactive behavior?	1	2	3	4	5	6	7
…discipline problems?	1	2	3	4	5	6	7
DAYTIME PROBLEMS							
During the past *4 weeks*, how often has your child had…							
…excessive daytime drowsiness or sleepiness?	1	2	3	4	5	6	7
…poor attention span or concentration?	1	2	3	4	5	6	7
…difficulty getting out of bed in the morning?	1	2	3	4	5	6	7
CAREGIVER CONCERNS							
During the past *4 weeks*, how often have the above problems…							
…caused you to worry about your child's general health?	1	2	3	4	5	6	7
…created concern that your child is not getting enough air?	1	2	3	4	5	6	7
…interfered with your ability to perform daily activities?	1	2	3	4	5	6	7
…made you frustrated?	1	2	3	4	5	6	7

OVERALL, HOW WOULD YOU RATE YOUR CHILD'S QUALITY OF LIFE AS A RESULT OF THE ABOVE PROBLEMS?
(Circle one number)

0 1 2 3 4 5 6 7 8 9 10

Worse Possible Quality-of-Life

Half-way Between Worst and Best

Best Possible Quality-of-Life

C
H
A
T

CHILDHOOD ADENOTONSILLECTOMY STUDY
OSA-18 Quality of Life Survey
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __ __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

Please answer all of the following questions:

	None of the time	Hardly any of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
Sleep Disturbance							
1. During the past 4 weeks, how often has your child had:							
1a. Loud Snoring?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
1b. Breath holding spells or pauses in breathing at night?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
1c. Chocking or gasping sounds while asleep?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
1d. Restless sleep or frequent awakenings from sleep?	☐0	☐1	☐2	☐3	☐4	☐5	☐6

Physical Suffering							
2. During the past 4 weeks, how often has your child had:							
2a. Mouth breathing because of nasal obstruction?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
2b. Frequent colds or upper respiratory infections?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
2c. Nasal discharge or runny nose?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
2d. Difficulty in swallowing foods?	☐0	☐1	☐2	☐3	☐4	☐5	☐6

Emotional Distress							
3. During the past 4 weeks, how often has your child had:							
3a. Mood swings or temper tantrums?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
3b. Aggressive or hyperactive behavior?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
3c. Discipline problems?	☐0	☐1	☐2	☐3	☐4	☐5	☐6

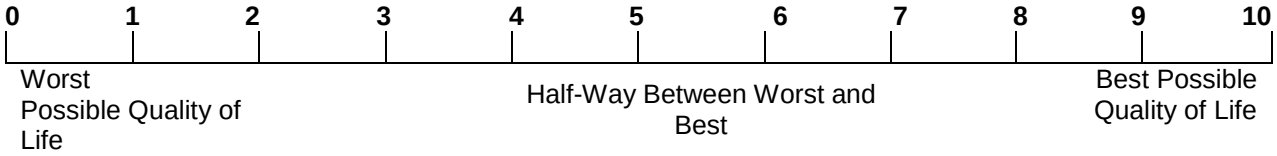
Daytime Problems							
4. During the past 4 weeks, how often has your child had:							
4a. Excessive daytime drowsiness or sleepiness?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
4b. Poor attention span or concentration?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
4c. Difficulty getting out of bed in the morning?	☐0	☐1	☐2	☐3	☐4	☐5	☐6

CHILDHOOD ADENOTONSILLECTOMY STUDY
OSA-18 Quality of Life Survey
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __ __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

	None of the time	Hardly any of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
Caregiver Concerns							
5. During the past 4 weeks, how often have the above problems:							
5a. Caused you to worry about your child's general health?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
5b. Created concern that your child is not getting enough air?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
5c. Interfered with your ability to perform daily activities?	☐0	☐1	☐2	☐3	☐4	☐5	☐6
5d. Made you frustrated?	☐0	☐1	☐2	☐3	☐4	☐5	☐6

6. Overall, how would you rate your child's quality of life as a result of the above problems? (Provide number based on chart below) __ __



C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
PedsQL – Parent Report (Ages 5-7)
Visit __ __

[Parent Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

DIRECTIONS:
The following is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for your child during the **past ONE month** by checking the appropriate box below. There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past ***ONE month***, how much of a problem has your child had with…

1.	Physical Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
1a.	Walking more than one block?	☐0	☐1	☐2	☐3	☐4
1b.	Running?	☐0	☐1	☐2	☐3	☐4
1c.	Participating in sports activity or exercise?	☐0	☐1	☐2	☐3	☐4
1d.	Lifting something heavy?	☐0	☐1	☐2	☐3	☐4
1e.	Taking a bath or shower by him or herself?	☐0	☐1	☐2	☐3	☐4
1f.	Doing chores like picking up his or her toys?	☐0	☐1	☐2	☐3	☐4
1g.	Having hurts or aches?	☐0	☐1	☐2	☐3	☐4
1h.	Low energy level?	☐0	☐1	☐2	☐3	☐4

2.	Emotional Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
2a.	Feeling afraid or scared?	☐0	☐1	☐2	☐3	☐4
2b.	Feeling sad or blue?	☐0	☐1	☐2	☐3	☐4
2c.	Feeling angry?	☐0	☐1	☐2	☐3	☐4
2d.	Trouble sleeping?	☐0	☐1	☐2	☐3	☐4
2e.	Worrying about what will happen to him / her?	☐0	☐1	☐2	☐3	☐4

3.	Social Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
3a.	Getting along with other children?	☐0	☐1	☐2	☐3	☐4
3b.	Other kids not wanting to be his or her friend?	☐0	☐1	☐2	☐3	☐4
3c.	Getting teased by other children?	☐0	☐1	☐2	☐3	☐4
3d.	Not able to do things that other children his or her age can do?	☐0	☐1	☐2	☐3	☐4
3e.	Keeping up when playing with other children?	☐0	☐1	☐2	☐3	☐4

4.	School Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
4a.	Paying attention in class?	☐0	☐1	☐2	☐3	☐4
4b.	Forgetting things?	☐0	☐1	☐2	☐3	☐4
4c.	Keeping up with school activities?	☐0	☐1	☐2	☐3	☐4
4d.	Missing school because of not feeling well?	☐0	☐1	☐2	☐3	☐4
4e.	Missing school to go to the doctor or hospital?	☐0	☐1	☐2	☐3	☐4

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
PedsQL – Parent Report (Ages 8-12)
Visit __ __

[Parent Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

DIRECTIONS:
The following is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for your child during the **past ONE month** by checking the appropriate box below. There are no right or wrong answers. If you do not understand a question, please ask for help.

In the past ***ONE month***, how much of a problem has your child had with…

1.	Physical Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
1a.	Walking more than one block?	☐0	☐1	☐2	☐3	☐4
1b.	Running?	☐0	☐1	☐2	☐3	☐4
1c.	Participating in sports activity or exercise?	☐0	☐1	☐2	☐3	☐4
1d.	Lifting something heavy?	☐0	☐1	☐2	☐3	☐4
1e.	Taking a bath or shower by him or herself?	☐0	☐1	☐2	☐3	☐4
1f.	Doing chores like picking up his or her toys?	☐0	☐1	☐2	☐3	☐4
1g.	Having hurts or aches?	☐0	☐1	☐2	☐3	☐4
1h.	Low energy level?	☐0	☐1	☐2	☐3	☐4

2.	Emotional Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
2a.	Feeling afraid or scared?	☐0	☐1	☐2	☐3	☐4
2b.	Feeling sad or blue?	☐0	☐1	☐2	☐3	☐4
2c.	Feeling angry?	☐0	☐1	☐2	☐3	☐4
2d.	Trouble sleeping?	☐0	☐1	☐2	☐3	☐4
2e.	Worrying about what will happen to him / her?	☐0	☐1	☐2	☐3	☐4

3.	Social Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
3a.	Getting along with other children?	☐0	☐1	☐2	☐3	☐4
3b.	Other kids not wanting to be his or her friend?	☐0	☐1	☐2	☐3	☐4
3c.	Getting teased by other children?	☐0	☐1	☐2	☐3	☐4
3d.	Not able to do things that other children his or her age can do?	☐0	☐1	☐2	☐3	☐4
3e.	Keeping up when playing with other children?	☐0	☐1	☐2	☐3	☐4

4.	School Functioning (problems with):	**Never**	**Almost Never**	**Sometimes**	**Often**	**Almost Always**
4a.	Paying attention in class?	☐0	☐1	☐2	☐3	☐4
4b.	Forgetting things?	☐0	☐1	☐2	☐3	☐4
4c.	Keeping up with school activities?	☐0	☐1	☐2	☐3	☐4
4d.	Missing school because of not feeling well?	☐0	☐1	☐2	☐3	☐4
4e.	Missing school to go to the doctor or hospital?	☐0	☐1	☐2	☐3	☐4

CHILDHOOD ADENOTONSILLECTOMY STUDY
Parent / Household Information
BASELINE

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

Parental Information:

Questions 1 – 4 pertain to the child's birth parents.

1. What is the mother's ethnicity?
   - ☐ 1 Hispanic or Latino
   - ☐ 2 Not Hispanic or Latino
   - ☐ 88 Not Sure

2. What is the mother's race?
   - ☐ 1 American Indian / Native Alaskan
   - ☐ 2 Asian
   - ☐ 3 Native Hawaiian / Other Pacific Islander
   - ☐ 4 Black / African American
   - ☐ 5 White / Caucasian
   - ☐ 6 Multiracial
   - ☐ 88 Not Sure
   - ☐ 98 Other, specify: _____

3. What is the father's ethnicity?
   - ☐ 1 Hispanic or Latino
   - ☐ 2 Not Hispanic or Latino
   - ☐ 88 Not Sure

4. What is the father's race?
   - ☐ 1 American Indian / Native Alaskan
   - ☐ 2 Asian
   - ☐ 3 Native Hawaiian / Other Pacific Islander
   - ☐ 4 Black / African American
   - ☐ 5 White / Caucasian
   - ☐ 6 Multiracial
   - ☐ 88 Not Sure
   - ☐ 98 Other, specify: _____

Household Information:

Questions 5 – 9 pertain to the child's current housing situation.

5. What is your annual household income before taxes?
   - ☐ 1 Under $5,000
   - ☐ 2 $5,000 to $9,999
   - ☐ 3 $10,000 to $19,999
   - ☐ 4 $20,000 to $29,999
   - ☐ 5 $30,000 to $39,999
   - ☐ 6 $40,000 to $49,999
   - ☐ 7 $50,000 to $59,999
   - ☐ 8 $60,000 and above
   - ☐ 97 Prefer not to answer

6. What is the highest level of education completed by the mother?

☐ 1 8th grade or less than 8th grade
☐ 2 9th – 11th grade
☐ 3 High school diploma or GED
☐ 4 Vocational, trade school, or Associate's degree
☐ 5 Courses toward college degree
☐ 6 Bachelor's Degree or 4-year college degree
☐ 7 Master's Degree
☐ 8 Professional Degree (M.D., Ph.D., J.D., etc)
☐ 88 Not Sure

7. What is the highest level of education completed by the father?

☐ 1 8th grade or less than 8th grade
☐ 2 9th – 11th grade
☐ 3 High school diploma or GED
☐ 4 Vocational, trade school, or Associate's degree
☐ 5 Courses toward college degree
☐ 6 Bachelor's Degree or 4-year college degree
☐ 7 Master's Degree
☐ 8 Professional Degree (M.D., Ph.D., J.D., etc)
☐ 88 Not Sure

8. What is the mother's current employment status?

☐ 1 Working full-time (35 or more hours per week)
☐ 2 Working part-time (35 or less hours per week)
☐ 3 Home keeper
☐ 4 Unemployed, looking for work
☐ 5 Unemployed, not looking for work
☐ 6 Student
☐ 7 Retired
☐ 8 Unable to work, specify: _____
☐ 88 Not Sure

9. What is the father's current employment status?

☐ 1 Working full-time (35 or more hours per week)
☐ 2 Working part-time (35 or less hours per week)
☐ 3 Home keeper
☐ 4 Unemployed, looking for work
☐ 5 Unemployed, not looking for work
☐ 6 Student
☐ 7 Retired
☐ 8 Unable to work, specify: _____
☐ 88 Not Sure

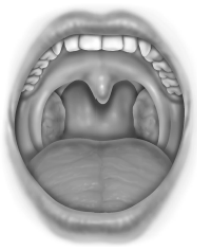
CHILDHOOD ADENOTONSILLECTOMY STUDY
Physical Examination
Baseline Visit

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

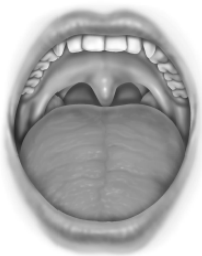
1. Temp: ___ ___ ___.___ ° C
2. Pulse: ___ ___ ___
3. Resp: ___ ___ ___

SYSTEM	NORMAL	ABNORMAL (explain)	NOT DONE
4. Constitutional	☐1	☐2 _____	☐99
5. Skin	☐1	☐2 _____	☐99
6. HEENT	☐1	☐2 _____	☐99
7. Neck	☐1	☐2 _____	☐99
8. Respiratory (Not OSAS)	☐1	☐2 _____	☐99
9. Cardiovascular	☐1	☐2 _____	☐99
10. Abdomen	☐1	☐2 _____	☐99
11. Musculoskeletal	☐1	☐2 _____	☐99
12. Extremities	☐1	☐2 _____	☐99
13. Lymphatics	☐1	☐2 _____	☐99
14. Neurologic	☐1	☐2 _____	☐99

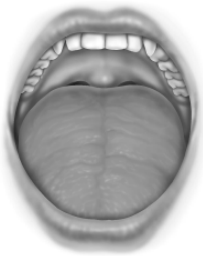
15. What is the Friedman palate position? ☐99 Not Done
(Please refer to the photos below)



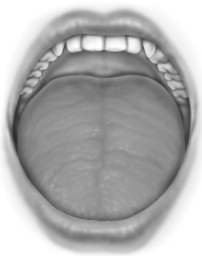
☐1 Position I



☐2 Position II



☐3 Position III



☐4 Position IV

16. What is the Mallampati position? ☐99 Not Done
(Please refer to the photos below)

☐1 Class I

☐2 Class II

☐3 Class III

☐4 Class IV

17. Does the child have any known allergies? ☐0 No ☐1 Yes

17a. If Yes, what allergies (check all that apply):

☐1 Molds ☐2 Trees ☐3 Cats ☐4 Insects
☐5 Dust ☐6 Grass or Pollen ☐7 Dogs ☐8 Food / Drink
☐9 Latex ☐98 Other, specify: _____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Physical Examination
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Temp: ___ ___ ___.___ ° C
2. Pulse: ___ ___ ___
3. Resp: ___ ___ ___

SYSTEM	NORMAL	ABNORMAL (explain)	NOT DONE
4. Constitutional	☐1	☐2 _____	☐99
5. Skin	☐1	☐2 _____	☐99
6. HEENT	☐1	☐2 _____	☐99
7. Neck	☐1	☐2 _____	☐99
8. Respiratory (Not OSAS)	☐1	☐2 _____	☐99
9. Cardiovascular	☐1	☐2 _____	☐99
10. Abdomen	☐1	☐2 _____	☐99
11. Musculoskeletal	☐1	☐2 _____	☐99
12. Extremities	☐1	☐2 _____	☐99
13. Lymphatics	☐1	☐2 _____	☐99
14. Neurologic	☐1	☐2 _____	☐99

15. Since the last visit, has the child developed any allergies? ☐0 No ☐1 Yes

15a. If Yes, what allergies (check all that apply):

☐1 Molds ☐2 Trees ☐3 Cats ☐4 Insects
☐5 Dust ☐6 Grass or Pollen ☐7 Dogs ☐8 Food / Drink
☐9 Latex ☐98 Other, specify: _____

16. Since the last visit, has the child begun any new or alternative medical treatments? ☐0 No ☐1 Yes

16a. If Yes, what treatment:

☐1 Nasal Steroids ☐2 CPAP or BIPAP ☐3 Oxygen Therapy
☐4 Oral Device ☐5 Surgery (other than TA)
☐98 Other, specify: _____

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Phone Contact
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

---

1. Since your last visit (__ __ / __ __ / __ __ __ __), how often has your child snored during sleep?

☐$_0$ Never
☐$_1$ Rarely (less than once a week)
☐$_2$ Sometimes (1 to 2 times per week)
☐$_3$ Frequently (3 to 4 times per week)
☐$_4$ Always or Almost Always (5 to 7 times per week)
☐$_{88}$ Not Sure

2. Has the child used the nasal spray in the past 30 days? ☐$_0$ No ☐$_1$ Yes

   2a. If Yes, approximately how many times per week?

☐$_1$ More than 7 times
☐$_2$ 7 – 5 times
☐$_3$ 4 – 2 times
☐$_4$ 1 time
☐$_{88}$ Not sure

   2b. What time of day does the child use the spray?

☐$_1$ Mostly at night
☐$_2$ Mostly in the morning
☐$_3$ Throughout the day
☐$_{88}$ Not sure

3. Has your child had any new medical problems, hospitalizations, or Emergency Room visits since your last visit (__ __ / __ __ / __ __ __ __)? ☐$_0$ No ☐$_1$ Yes

   3a. If Yes, list: _____ (Reason) ____ / __ __ / __ __ __ __ (Date)

Note – if a condition is recorded above, add it to the AE form

4. Has the child begun any new medications? ☐$_0$ No ☐$_1$ Yes

   4a. If Yes, list: _____ (Medication) ____ / __ __ / __ __ __ __ (Date)

Note – these medications will need to be added to the CMED form

5. Since your last visit (__ __ / __ __ / __ __ __ __), has your child had any of the following during sleep?

		Never	**Rarely** (less than once a week)	**Sometimes** (1 to 2 times per week)	**Frequently** (3 to 4 times per week)	**Always or Almost Always** (5 to 7 times per week)	**Not Sure**
5a.	Chest is wheezy or whistling	☐$_0$	☐$_1$	☐$_2$	☐$_3$	☐$_4$	☐$_{88}$
5b.	Frequent Awakenings	☐$_0$	☐$_1$	☐$_2$	☐$_3$	☐$_4$	☐$_{88}$
5c.	Stop Breathing	☐$_0$	☐$_1$	☐$_2$	☐$_3$	☐$_4$	☐$_{88}$
5d.	Daytime Sleepiness	☐$_0$	☐$_1$	☐$_2$	☐$_3$	☐$_4$	☐$_{88}$

Comments: _____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Post-Op Phone Call
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

---

1. Please provide the Surgeon ID: __ __ - __ __

2. After their adenotonsillectomy, did the child require evaluation in the ER, other surgery or admission to the hospital for any reason or did they require evaluation in the ENT clinic for any reason other than a routine post-operative follow-up visit? ☐0 No ☐1 Yes

   2a. If Yes, what was the reason?
   ☐1 Dehydration requiring IV Fluid
   ☐2 Dehydration requiring Admission*****
   ☐3 Bleeding requiring Admission*****
   ☐4 Bleeding requiring return to OR*****
   ☐5 Other Admission*****, specify:
   _____
   _____
   ☐98 Other, specify:
   _____
   _____

**** Serious Adverse Event, requires immediate action as outline in the MOP ****

3. Did the child have post operative pain requiring pain medication for greater than 3 weeks after surgery? ☐0 No ☐1 Yes

4. Are there any current eating or drinking concerns? ☐0 No ☐1 Yes

   4a. Has this concern required evaluation or care by a medical professional? ☐0 No ☐1 Yes

5. Are there any current concerns about the child's voice? ☐0 No ☐1 Yes

   5a. Has this concern required evaluation or care by a medical professional? ☐0 No ☐1 Yes

6. Has the breathing or snoring of the child worsened since surgery? ☐0 No ☐1 Yes

7. Are there any other major health concerns? ☐0 No ☐1 Yes
   If Yes and necessity warrants, please complete an Adverse Event form.

8. Has the child begun any new medications? ☐0 No ☐1 Yes
   If Yes, please complete the CMED form.

Comments: _____

_____

_____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Post-Op Phone Call
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Please provide the Surgeon ID: __ __ - __ __

2. After their adenotonsillectomy, did the child require evaluation in the ER, other surgery or admission to the hospital for any reason or did they require evaluation in the ENT clinic for any reason other than a routine post-operative follow-up visit? ☐0 No ☐1 Yes

   2a. If Yes, what was the reason? ☐1 Other Admission*****, specify: _____

   _____

   ☐98 Other, specify: _____

   _____

**** Serious Adverse Event, requires immediate action as outline in the MOP ****

3. Are there any current eating or drinking concerns? ☐0 No ☐1 Yes

   3a. Has this concern required evaluation or care by a medical professional? ☐0 No ☐1 Yes

4. Are there any current concerns about the child's voice? ☐0 No ☐1 Yes

   4a. Has this concern required evaluation or care by a medical professional? ☐0 No ☐1 Yes

5. Has the breathing or snoring of the child worsened since surgery? ☐0 No ☐1 Yes

6. In the past 30 days, have there been any other major health concerns? ☐0 No ☐1 Yes
   If Yes and necessity warrants, please complete an Adverse Event form.

7. In the past 30 days, has the child begun any new medications? ☐0 No ☐1 Yes
   If Yes, please complete the CMED form.

Comments: _____

_____

_____

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Pre-Operative Questionnaire
SCREEN

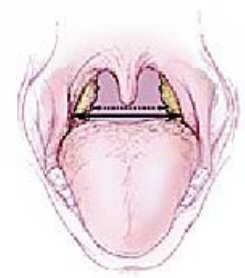
Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. How was this information obtained?

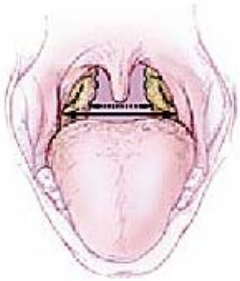
☐1 Chart Review from previous ENT evaluation
☐2 Current ENT evaluation

2. What was the pre-operation Tonsil size?
(Please refer to the photos below)

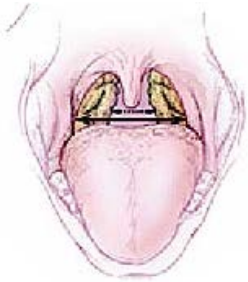
☐99 Not Done



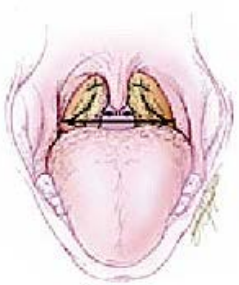
☐1 1+ 0 – 25%



☐2 2+ 26 – 50%



☐3 3+ 51 – 75%



☐4 4+ 76 – 100%

3. Is the child a candidate for Adenotonsillectomy? ☐0 No ☐1 Yes

4. Are there any known contraindications for surgery? ☐0 No ☐1 Yes

5. What is the Surgeon ID? __ __ - __ __

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Pediatric Sleep Questionnaire
Visit __ __

[Parent Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1.	While sleeping, does your child:			
	1a. Snore more than half the time?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	1b. Always snore?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	1c. Snore loudly?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	1d. Have "heavy" or loud breathing?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	1e. Have trouble breathing, or struggle to breathe?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
2.	Have you ever seen your child stop breathing during the night?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
3.	Does your child:			
	3a. Tend to breathe through the mouth during the day?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	3b. Have a dry mouth on waking up in the morning?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	3c. Occasionally wet the bed?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
4.	Does your child:			
	4a. Wake up feeling unrefreshed in the morning?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	4b. Have a problem with sleepiness during the day?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
5.	Has a teacher or other supervisor commented that your child appears sleepy during the day?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
6.	Is it hard to wake your child up in the morning?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
7.	Does your child wake up with headaches in the morning?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
8.	Did your child stop growing at a normal rate at any time since birth?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
9.	Is your child overweight?	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
10.	This child **OFTEN**:			
	10a. Does not seem to listen when spoken to directly.	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	10b. Has difficulty organizing tasks and activities.	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	10c. Is easily distracted by extraneous stimuli.	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	10d. Fidgets with hands or feet or squirms in seat.	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	10e. Is "on the go" or often acts as if "driven by a motor".	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know
	10f. Interrupts or intrudes on others (eg: butts into conversations or games).	☐$_1$ Yes	☐$_0$ No	☐$_{88}$ Don't Know

CHILDHOOD ADENOTONSILLECTOMY STUDY

Prescreening & Screening Summary

Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC-ID: __ __ - __ __

These data should be collected and entered into the Prescreening & Screening Summary Module in the DMS bi-weekly, by the End of Business on Friday. These data will help provide monthly reports on enrollment, recruitment, and retention per site for the duration of the study.

Pre-Screening Data:

1. How many participant contacts were made by site staff this week (please indicate the number for each of the contact methods listed below):

   1a. Participants recruited through chart review: __ __ __

   1b. Participants recruited through clinic referral (ENT, PSG, sleep lab, etc): __ __ __

   1c. Participants recruited through CHAT flyers, brochures, or other media: __ __ __

   1d. Participant recruited through other means: __ __ __

   Describe other means: _____

   1e. Total number of participants contacted: __ __ __
   Note: Add columns 1a – 1d.

2. What is the status of the participants contacted above (please indicate the number for each category below):

   2a. Participants eligible for screening: __ __ __

   2b. Participants ***not*** eligible for screening: __ __ __
   Note: If participant is a screen failure, fill out the SSTOP CRF.

   2c. Participants ***not*** interested in participating: __ __ __

   2d. Total number of participants assessed for screening: __ __ __
   Note: Add columns 2a – 2c.

Screening Data:

3. How many of the screened participants were eligible for randomization: __ __ __

4. How many of the screened participants were ***not*** eligible for randomization: __ __ __

1. Was this test performed?

☐ 0 No
☐ 1 Yes

For Question 2, please provide the summary scores from the Purdue Pegboard test

2.

		Hand	Number of Pegs
2a.	Dominant Hand:	☐ 1 Right ☐ 2 Left	__ __
2b.	Non-dominant Hand:	☐ 1 Right ☐ 2 Left	__ __
2c.	Both Hands:		__ __

CHILDHOOD ADENOTONSILLECTOMY STUDY
Randomization

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Has the participant met all eligibility criteria and signed the consent form; and the PI has reviewed and certified the individual as being eligible?

   ☐ 0 No
   ☐ 1 Yes

2. Has the participant had an ENT evaluation within 90 days of baseline, and is considered a candidate for surgery?

   ☐ 0 No
   ☐ 1 Yes

3. Has the participant had an overnight PSG evaluation, and is within the protocol defined limits?

   ☐ 0 No
   ☐ 1 Yes

4. Was the child able to perform the neurocognitive testing?

   ☐ 0 No
   ☐ 1 Yes

5. Date the parent signed the consent form:

   __ __ / __ __ / __ __ __ __
   M M D D Y Y Y Y

6. Date of Randomization:

   __ __ / __ __ / __ __ __ __
   M M D D Y Y Y Y

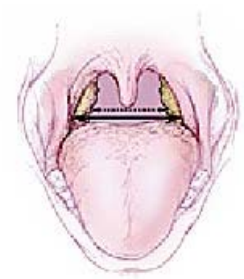
7. Randomization Code assigned by DMS: __

CHILDHOOD ADENOTONSILLECTOMY STUDY
Reevaluation for Surgical Candidacy
Visit T2

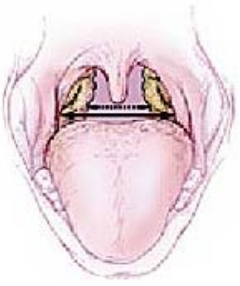
Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Was reevaluation for surgical candidacy performed? ☐0 No ☐1 Yes

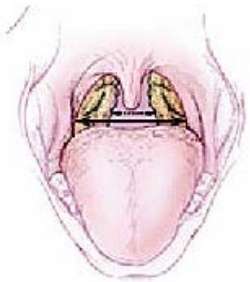
2. What was the current Tonsil size? ☐99 Not Done
(Please refer to the photos below)



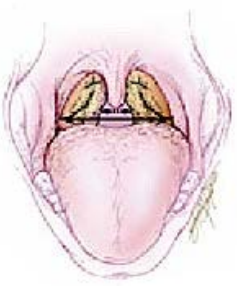
☐1 1+ 0 – 25%



☐2 2+ 26 – 50%



☐3 3+ 51 – 75%



☐4 4+ 76 – 100%

3. Is the child still considered to be a candidate for Adenotonsillectomy? ☐0 No ☐1 Yes

4. Are there any known contraindications for surgery? ☐0 No ☐1 Yes

5. What is the Surgeon ID? __ __ - __ __

CHILDHOOD ADENOTONSILLECTOMY STUDY
Referral Source and Demographics
SCREEN

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Participant was recruited from which source:

☐1 OTL
☐2 Sleep Clinic
☐3 Sleep Lab
☐4 Pediatric Clinic
☐5 Community
☐6 Advertisement
☐7 Chart Review
☐98 Other, specify:_____

2. What is the child's Date of Birth?

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

3. What is the Screening PSG date?

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

4. What is the child's race?

☐1 American Indian / Native Alaskan
☐2 Asian
☐3 Native Hawaiian / Other Pacific Islander
☐4 Black / African American
☐5 White / Caucasian
☐6 Multiracial
☐98 Other, specify: _____

5. What is the child's ethnicity?

☐1 Hispanic or Latino
☐2 Not Hispanic or Latino

6. What is the child's standing height? ***** __ __ __ . __ __ cm

7. What is the child's weight? ***** __ __ __ . __ __ kg

8. What is the child's BMI? ***** __ __ __ . __ __

**** Indicate measurement at time of PSG screening.***

9. What is the child's gender?

☐1 Male
☐2 Female

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Sleep Journal
Visit __ __

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

Please maintain this log for 5 consecutive days. Complete these questions first thing in the morning of each day.

1. Please provide the day: ____ Enter a number from 1 - 5

2. What is today's date? __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)

3. At what time did your child go to bed and try to fall asleep last night? __ __ : __ __ ☐1 AM ☐2 PM

4. Did your child wake up during the night? ☐0 No ☐1 Yes

   4a. If YES, please provide the times:
   1) __ __ : __ __ ☐1 AM ☐2 PM
   2) __ __ : __ __ ☐1 AM ☐2 PM
   3) __ __ : __ __ ☐1 AM ☐2 PM

5. What time did your child first wake up today? __ __ : __ __ ☐1 AM ☐2 PM

6. Did your child go back to sleep after first waking up? ☐0 No ☐1 Yes

   6a. If YES, what time did they get up and out of bed? __ __ : __ __ ☐1 AM ☐2 PM

7. Did your child take any naps yesterday? ☐0 No ☐1 Yes

   If YES, please provide the times:

	Nap Begin	**Nap End**
7a.	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM
7b.	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM

8. Did your child go to school yesterday? ☐0 No ☐1 Yes ☐99 Not Applicable / Child not in school

9. Was your child sick yesterday? ☐0 No ☐1 Yes

   9a. If YES, with what? _____

10. Did your child take any medication(s) yesterday? ☐0 No ☐1 Yes

    10a. If YES, list medication(s): _____

11. How many 8oz (1 cup) caffeinated beverages did your child drink yesterday? __ __

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Sleep and Health Questionnaire
BASELINE

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

---

1. During the past 6 months, at what time, on average has your child:

		Weekdays:	Weekends:
1a.	Gone to bed? (first closed the eyes in attempt to fall asleep)	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM
1b.	Fallen asleep?	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM
1c.	Woken up? (after the sleep period)	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM

2. Has your child snored in the **last month**?
   ☐0 No
   ☐1 Yes
   ☐88 Not sure

   If Yes, answer 2a – 2d; referring to your child's snoring in the last month:

   2a. How often has your child experienced loud snoring during sleep?
   ☐0 Never
   ☐1 Rarely (less than once a week)
   ☐2 Sometimes (1 to 2 times per week)
   ☐3 Frequently (3 to 4 times per week)
   ☐4 Always or Almost Always (5 to 7 times per week)
   ☐88 Not Sure

   2b. Has your child's snoring usually been:
   ☐1 Only slightly louder than heavy breathing
   ☐2 About as loud as mumbling or talking
   ☐3 Louder than talking
   ☐4 Extremely loud – can be heard through closed doors
   ☐88 Not Sure

   2c. Has the snoring sounded:
   ☐1 The same with each breath (snore)
   ☐2 Sometimes loud, sometimes soft
   ☐88 Not Sure

   2d. Was your child's snoring so loud it disturbed others?
   ☐0 No
   ☐1 Yes
   ☐88 Not sure

3. How old was your child when he / she first started snoring? __ __ years ☐88 Not sure

3a. During the entire time your child has snored, has his / her snoring usually been?

☐1 Only slightly louder than heavy breathing
☐2 About as loud as mumbling or talking
☐3 Louder than talking
☐4 Extremely loud – can be heard through closed doors
☐88 Not Sure

3b. Has your child's snoring EVER been so loud it disturbed others?

☐0 No
☐1 Yes
☐88 Not sure

If Yes, answer 3c:

3c. Approximately how many years has the snoring been this loud?

__ __ years ☐88 Not sure

4. Do you watch your child while he / she is asleep at night because you are afraid about his / her breathing?

☐0 No
☐1 Yes
☐2 Only when child was younger than 5 years old

5. In the **PAST YEAR**, has your child had the following:

		No	Yes	Not Sure
5a.	Frequent colds or flu?	☐0	☐1	☐88
5b.	Frequent ear infections?	☐0	☐1	☐88
5c.	Difficulty swallowing?	☐0	☐1	☐88
5d.	Speech problems?	☐0	☐1	☐88

		No	Yes	Not In School	Not Sure
5e.	Difficulties with school work related to attention problems or sleepiness?	☐0	☐1	☐2	☐88
5f.	Difficulties with school work related to behavior problems?	☐0	☐1	☐2	☐88
5g.	Difficulties interacting with others or in a group setting because of behavior problems?	☐0	☐1	☐2	☐88

		No	Yes	Not Sure
5h.	Extreme irritability or mood problems?	☐0	☐1	☐88
5i.	Has your child been professionally counseled for a behavior problem?	☐0	☐1	☐88
5j.	Has your child been referred for special help in school?	☐0	☐1	☐88

6. Over the **PAST MONTH**, has your child had any of the following during sleep?

		Never	**Rarely** (less than once a week)	**Sometimes** (1 to 2 times per week)	**Frequently** (3 to 4 times per week)	**Always or Almost Always** (5 to 7 times per week)	Not Sure
6a.	Breathing difficulty	☐0	☐1	☐2	☐3	☐4	☐88
6b.	Chest is wheezy or whistling	☐0	☐1	☐2	☐3	☐4	☐88
6c.	Frequent Awakenings	☐0	☐1	☐2	☐3	☐4	☐88
6d.	Frequent tossing, turning, or thrashing?	☐0	☐1	☐2	☐3	☐4	☐88
6e.	Heartburn	☐0	☐1	☐2	☐3	☐4	☐88
6f.	Legs are jumpy or jerky	☐0	☐1	☐2	☐3	☐4	☐88
6g.	Restlessness	☐0	☐1	☐2	☐3	☐4	☐88
6h.	Talk during sleep	☐0	☐1	☐2	☐3	☐4	☐88
6i.	Walk during sleep	☐0	☐1	☐2	☐3	☐4	☐88

7. At what time of day does your child function best?
☐1 Morning
☐2 Afternoon
☐3 Evening
☐4 No best time

8. In the **PAST 3 Months**, on average, how much time has your child spent doing the following:
Note: Enter 0 if you did not do any of the activities below

		Amount of Time Per Day	Number of Days Per Week
8a.	Walking for exercise or to school	__ __ H __ __ M	__ D
8b.	Jogging or running	__ __ H __ __ M	__ D
8c.	Bicycling	__ __ H __ __ M	__ D
8d.	Basketball, volley ball or other sports involving running or jumping	__ __ H __ __ M	__ D
8e.	Swimming	__ __ H __ __ M	__ D
8f.	Jump rope	__ __ H __ __ M	__ D
8g.	In gym class or PE, being active	__ __ H __ __ M	__ D
8h.	Other activity (specify): _____	__ __ H __ __ M	__ D

9. On average how many beverages containing caffeine (cola, coffee, tea, etc.) does your child drink per day?
*** One can of soda = 1.5 cups; 1 20oz bottle = 2.5 cups ***

- ☐ 0 None
- ☐ 1 Less than one cup per day
- ☐ 2 Approximately one cup (8oz) per day
- ☐ 3 More than one cup, but not more than three cups per day
- ☐ 4 More than three cups per day

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Sleep and Health Questionnaire
Visit __ __

[Parent / Guardian Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

---

1. Since your last visit, at what time, on average has your child:

		Weekdays:	Weekends:
1a.	Gone to bed? (first closed the eyes in attempt to fall asleep)	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM
1b.	Fallen asleep?	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM
1c.	Woken up? (after the sleep period)	__ __ : __ __ ☐1 AM ☐2 PM	__ __ : __ __ ☐1 AM ☐2 PM

2. Has your child snored in the **last month**?
   ☐0 No
   ☐1 Yes
   ☐88 Not sure

If Yes, answer 2a – 2d; referring to your child's snoring in the last month:

2a. In the last month, how often has your child experienced loud snoring during sleep?
   ☐0 Never
   ☐1 Rarely (less than once a week)
   ☐2 Sometimes (1 to 2 times per week)
   ☐3 Frequently (3 to 4 times per week)
   ☐4 Always or Almost Always (5 to 7 times per week)
   ☐88 Not Sure

2b. In the last month, has your child's snoring usually been:
   ☐1 Only slightly louder than heavy breathing
   ☐2 About as loud as mumbling or talking
   ☐3 Louder than talking
   ☐4 Extremely loud – can be heard through closed doors
   ☐88 Not Sure

2c. In the last month, has the snoring sounded:
   ☐1 The same with each breath (snore)
   ☐2 Sometimes loud, sometimes soft
   ☐88 Not Sure

2d. In the last month, was your child's snoring so loud it disturbed others?
   ☐0 No
   ☐1 Yes
   ☐88 Not sure

3. Do you watch your child while he / she is asleep at night because you are afraid about his / her breathing?
   ☐0 No
   ☐1 Yes
   ☐2 Only when child was younger than 5 years old

4. In the **PAST 6 MONTHS**, has your child had the following:

		No	Yes	Not Sure
4a.	Frequent colds or flu?	☐0	☐1	☐88
4b.	Frequent ear infections?	☐0	☐1	☐88
4c.	Difficulty swallowing?	☐0	☐1	☐88
4d.	Speech problems?	☐0	☐1	☐88

		No	Yes	Not In School	Not Sure
4e.	Difficulties with school work related to attention problems or sleepiness?	☐0	☐1	☐2	☐88
4f.	Difficulties with school work related to behavior problems?	☐0	☐1	☐2	☐88
4g.	Difficulties interacting with others or in a group setting because of behavior problems?	☐0	☐1	☐2	☐88

		No	Yes	Not Sure
4h.	Extreme irritability or mood problems?	☐0	☐1	☐88
4i.	Has your child been professionally counseled for a behavior problem?	☐0	☐1	☐88
4j.	Has your child been referred for special help in school?	☐0	☐1	☐88

5. Over the **PAST MONTH**, has your child had any of the following during sleep?

		Never	**Rarely** (less than once a week)	**Sometimes** (1 to 2 times per week)	**Frequently** (3 to 4 times per week)	**Always or Almost Always** (5 to 7 times per week)	**Not Sure**
5a.	Breathing difficulty	☐0	☐1	☐2	☐3	☐4	☐88
5b.	Chest is wheezy or whistling	☐0	☐1	☐2	☐3	☐4	☐88
5c.	Frequent Awakenings	☐0	☐1	☐2	☐3	☐4	☐88
5d.	Frequent tossing, turning, or thrashing?	☐0	☐1	☐2	☐3	☐4	☐88
5e.	Heartburn	☐0	☐1	☐2	☐3	☐4	☐88
5f.	Legs are jumpy or jerky	☐0	☐1	☐2	☐3	☐4	☐88
5g.	Restlessness	☐0	☐1	☐2	☐3	☐4	☐88
5h.	Talk during sleep	☐0	☐1	☐2	☐3	☐4	☐88
5i.	Walk during sleep	☐0	☐1	☐2	☐3	☐4	☐88

6. At what time of day does your child function best?
☐1 Morning
☐2 Afternoon
☐3 Evening
☐4 No best time

7. In the **PAST 3 Months**, on average, how much time has your child spent doing the following:
Note: Enter 0 if you did not do any of the activities below

		Amount of Time Per Day	**Number of Days Per Week**
7a.	Walking for exercise or to school	__ __ H __ __ M	__ D
7b.	Jogging or running	__ __ H __ __ M	__ D
7c.	Bicycling	__ __ H __ __ M	__ D
7d.	Basketball, volley ball or other sports involving running or jumping	__ __ H __ __ M	__ D
7e.	Swimming	__ __ H __ __ M	__ D
7f.	Jump rope	__ __ H __ __ M	__ D
7g.	In gym class or PE, being active	__ __ H __ __ M	__ D
7h.	Other activity (specify): _____	__ __ H __ __ M	__ D

8. On average how many beverages containing caffeine (cola, coffee, tea, etc.) does your child drink per day?
*** One can of soda = 1.5 cups; 1 20oz bottle = 2.5 cups ***

- ☐ 0 None
- ☐ 1 Less than one cup per day
- ☐ 2 Approximately one cup (8oz) per day
- ☐ 3 More than one cup, but not more than three cups per day
- ☐ 4 More than three cups per day

C H A T

CHILDHOOD ADENOTONSILLECTOMY STUDY
Modified Epworth Sleepiness Scale
Visit __ __

[Parent Completed]

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

How likely is your child to actually doze off or fall asleep in the following situations, *in contrast to feeling just tired*? This refers to his / her usual way of life in recent times. Even if he / she has not done some of these things recently, think about how they would have affected your child. Use the following scale to choose the *most appropriate number* for each situation:

It is important that you check ONE box (0 to 3) for each of the 10 questions:

		Chance of Dozing or Falling Asleep			
		No Chance	**Slight Chance**	**Moderate Chance**	**High Chance**
1.	Sitting and reading	☐0	☐1	☐2	☐3
2.	Watching TV	☐0	☐1	☐2	☐3
3.	Sitting, inactive in a public place (ergo: a class room or a movie theater)	☐0	☐1	☐2	☐3
4.	As a passenger in a car for an hour without a break	☐0	☐1	☐2	☐3
5.	Lying down to rest in the afternoon when circumstances permit	☐0	☐1	☐2	☐3
6.	Sitting and talking to someone	☐0	☐1	☐2	☐3
7.	Sitting quietly after lunch	☐0	☐1	☐2	☐3
8.	In a car, while stopped for a few minutes in traffic	☐0	☐1	☐2	☐3
9.	Doing homework or taking a test	☐0	☐1	☐2	☐3
10.	Playing a videogame	☐0	☐1	☐2	☐3

CHILDHOOD ADENOTONSILLECTOMY STUDY
Sleep Journal Summary
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Were the parent completed sleep journals returned? ☐0 No ☐1 Yes

2. Were the journals recorded for 5 days? ☐0 No ☐1 Yes

   2a. If No, how many days were recorded? ____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Study Stop

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

1. Did the participant complete the study, as per protocol? ☐0 No ☐1 Yes

   1a. If No, what was the last study visit the participant completed? __ __

2. Date the participant stopped: __ __ / __ __ / __ __ __ __ (M M D D Y Y Y Y)

3. What was the primary reason that the participant stopped?

   ☐1 Participant successfully completed all required study visits
   ☐2 Participant lost to follow-up
   ☐3 Participant withdrew consent
   ☐4 Protocol defined stopping rules, decrease in DASII performance
   ☐5 Screen failure as defined in MOP
   ☐6 New medical problem determined to make continued participation unsafe
   ☐7 New behavioral or learning problem determined to make continued participation unsafe
   ☐8 Participant declined their assigned randomization arm
   ☐9 Death
   ☐98 Other, specify: _____

   _____

Comments: _____

_____

_____

_____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Treatment Stop

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

NOTE: *This form should only be completed after a participant has been* ***RANDOMIZED****.*

1. Date the participant's treatment stopped: ____ / ____ / ____ (M M / D D / Y Y Y Y)

2. What is the primary reason that the participant's treatment was stopped?

- ☐ 1 Child's physician has identified a change in signs or symptoms that warrants alternative treatment for OSA (Initiation of CPAP for example)
- ☐ 2 Child has developed new academic or behavioral problems resulting in a recommendation for grade retention
- ☐ 3 Child has begun special education
- ☐ 4 Child has begun counseling or placement on medications for behavior or emotional problems
- ☐ 5 Recurrent bacterial tonsillitis (3 or more episodes of streptococcal culture positive infection occurring over a 3 month period)
- ☐ 6 New clinical diagnosis of cor pulmonale
- ☐ 7 Development of "failure to thrive" defined by weight loss during the course of follow-up
- ☐ 8 New onset Stage 2 Hypertension, which is not better explained by another medical condition
- ☐ 9 New onset hypersomnolence defined as reports of falling asleep on average > 3 times per week, which is not better explained by other factors unrelated to OSA
- ☐ 10 Parent / Caregiver decision to have Adenotonsillectomy Surgery (WWSC group)
- ☐ 11 Parent / Caregiver decision to not have Adenotonsillectomy Surgery (EAT group)
- ☐ 98 Other medical or neuropsychological necessitated reason, specify: _____

_____

3. Has the Medical Monitor confirmed this to be a treatment failure? ☐ 0 No ☐ 1 Yes

4. Did this participant crossover? ☐ 0 No ☐ 1 Yes

   4a. If yes, please indicate the primary reason:
   - ☐ 1 Crossover due to confirmed treatment failure
   - ☐ 2 Crossover due to parent / caregiver decision

5. Will the participant be continuing with follow-up visits? ☐ 0 No ☐ 1 Yes

Comments: _____

_____

_____

_____

CHILDHOOD ADENOTONSILLECTOMY STUDY
Unblinding of Participant

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

Research Coordinator completes this form if the participant needs to be unblinded. Photocopies of this form with signatures must be faxed to the DCC.

1. Date participant was unblinded: __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

2. What was the participant's randomization arm?
   - ☐ 1 Early Adenotonsillectomy (EAT)
   - ☐ 2 Watchful Waiting with Supportive Care (WWSC)

3. Why was the participant unblinded?
   - ☐ 1 Neuropsychological scores fell outside the accepted range
   - ☐ 2 Participant experienced an SAE related to medical intervention
   - ☐ 3 Parent or child inadvertently disclosed their treatment arm
   - ☐ 98 Other, specify: _____
     _____
     _____

4. Was the DCC contacted within 24 hours of unblinding?
   - ☐ 0 No
   - ☐ 1 Yes

   4a. If ***YES***, name of the person contacted: _____

   4b. If ***NO***, state the reason why: _____

PI Signature: _____ Date: __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y)

Directions: Fax this form to the DCC at (215) 573-6262

CHILDHOOD ADENOTONSILLECTOMY STUDY
Beery VMI
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Was the Beery VMI performed?
   - ☐ 0 No
   - ☐ 1 Yes

2. Please indicate the neuropsychological battery performed:
   - ☐ 1 Version 1
   - ☐ 2 Version 2

3. Please indicate the child's hand preference:
   - ☐ 1 Right
   - ☐ 2 Left
   - ☐ 3 Alternated Hands

Please provide the summary scores from the Beery VMI

		Beery VMI
4.	Raw Score:	
5.	Standard Score:	
6.	Percentile:	

CHILDHOOD ADENOTONSILLECTOMY STUDY
WRAML-2
Visit __ __

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
NP ID: __ __ - __ __

1. Were any of the sections of the WRAML-2 administered?

☐ 0 No
☐ 1 Yes

Please provide the summary data from the WRAML2

		Raw Score	Scaled Score
2.	Verbal Learning:		
3.	Verbal Learning Recall:		
4.	Verbal Learning Recognition:		