

# Survey Instructions

- Please answer ALL of the sections in the survey, even if they do not seem to be directly relevant to you. Your information is essential for this study and may also be important for studies of other types of cancer. Everything you tell us will be treated in the strictest confidence but you are free to leave blank any specific questions that you do not wish to answer.
- If you are not sure of the correct answer, please give us your best estimate. We are asking many different people the same sets of questions and we are very interested in the different types of responses.
- To make the questionnaire easier to complete, we have mostly used boxes that you can mark with either a cross. For example, if your answer is YES then please mark it clearly like this example. Yes  No
- Some of the questions ask you for a short written answer. If you need extra space for your answers, please use the space on the last page.
- Please detach the first page (invitation letter and copy of consent forms) for your records. Then fill in the Survey (pages 3-10), sign both consent forms (pages 11 and 12) and return the Survey and consent forms in the envelope provided.
- If you would prefer to complete the survey online, please visit [www.qskin.qimr.edu.au](http://www.qskin.qimr.edu.au) and follow the links to the survey. To gain access, please use your username and unique password on the front cover. If you complete the survey online, you do NOT need to send in this paper survey.

## Section A. First some questions about YOU

### Birth and Residence

**Q1. How old are you?**


years of age

**Q2. What best describes your current situation?**

- |  |   |
|--|---|
| <input type="checkbox"/> 1 Never married<br><input type="checkbox"/> 2 Married<br><input type="checkbox"/> 3 Defacto / living with a partner | <input type="checkbox"/> 4 Widowed<br><input type="checkbox"/> 5 Divorced<br><input type="checkbox"/> 6 Separated |
|--|---|

**Q3. Where were you born?**

Town / City

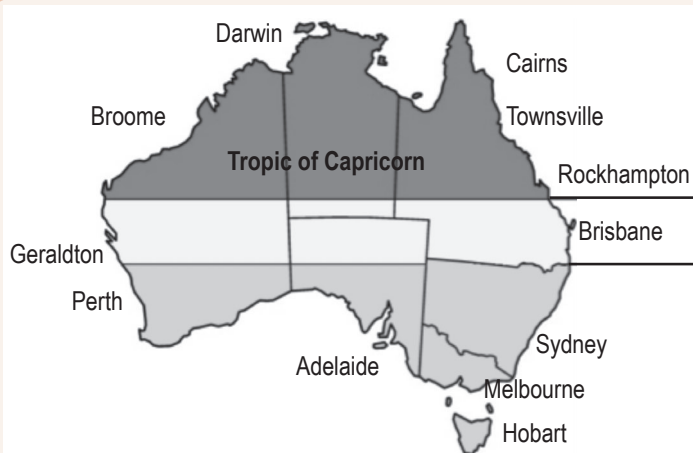
State / Province

Country

**Q4. If you were born overseas: How old were you when you moved permanently to Australia?**


years of age

**Q5. How many YEARS of your life have you lived in the following three regions of AUSTRALIA: (to the nearest year)**



Northern region

Central region

Southern region

Northern region

Central region

Southern region

**Where did you live the longest as a child/youth (up to age 20 years)? (see map above)**

 1

 2

 3

If you have lived outside Australia for more than ONE YEAR, please tell us where you lived, and for how many years.

State/Province AND Country that you lived in (list below)

Years as a child/youth (aged 0-20 years old)      Years as an adult (more than 20 years old)

State/Province AND Country that you lived in (list below)	Years as a child/youth (aged 0-20 years old)	Years as an adult (more than 20 years old)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

**Q6. Do you have private health insurance?**

Yes      No  
 1       2

**Q7. Are you a veteran; war widow/er; or spouse, carer, dependant of a veteran?**

Yes      No  
 1       2

**Q8. What is your ancestry? (That is, where did most of your ancestors come from?)**

(Many people have mixed ancestry. Please cross as many boxes as required)

<input type="checkbox"/> English	<input type="checkbox"/> Scottish	<input type="checkbox"/> Irish
<input type="checkbox"/> German	<input type="checkbox"/> Dutch	<input type="checkbox"/> Polish
<input type="checkbox"/> Italian	<input type="checkbox"/> Serbian	<input type="checkbox"/> Croatian
<input type="checkbox"/> Maltese	<input type="checkbox"/> Greek	<input type="checkbox"/> Turkish
<input type="checkbox"/> Lebanese	<input type="checkbox"/> Indian	<input type="checkbox"/> Chinese
<input type="checkbox"/> Filipino	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> South American
<input type="checkbox"/> Aboriginal or Torres Strait Islander	<input type="checkbox"/> South Sea Islander	<input type="checkbox"/> Australian
<input type="checkbox"/> Other (please specify)	<input type="text"/>	

## Education and work

**Q9. What is the highest qualification you have completed?**

- 1 No school certificate or other qualification
- 2 School or intermediate certificate (or equivalent)
- 3 Higher school or leaving certificate (or equivalent)
- 4 Trade / apprenticeship (e.g. hairdresser, chef)
- 5 Certificate / diploma (e.g. child care, technician)
- 6 University degree

**Q10. Which of the following best describes you NOW?**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> 1 Full-time worker       | <input type="checkbox"/> 4 Unemployed |
| <input type="checkbox"/> 2 Part-time worker       | <input type="checkbox"/> 5 Student    |
| <input type="checkbox"/> 3 Home duties            | <input type="checkbox"/> 6 Retired    |
| <input type="checkbox"/> 7 Other (please specify) | <input type="text"/>                  |

If you are a full-time or part-time worker, do you regularly do night shifts?

Yes      No  
 1       2

## Section B. Some questions about your colouring and skin

### Skin colour

**Q11.** How would you rate your natural skin colour on areas never exposed to the sun (like under your arm)?

1 Fair

3 Olive / Dark

2 Medium

4 Black

### Skin type

**Q12.** IMAGINE you did go out in the strong sun for 30 minutes in the middle of the day for the first time in summer, without protecting your skin with sunscreen or clothing. Which of the following would happen to you?

1 Not burn

3 Burn moderately

2 Burn a little

4 Burn badly

**Q13.** Now, IMAGINE you did spend several weeks outdoors in the sun, without protecting your skin with sunscreen or clothing. Which of the following would happen to your skin?

1 Not tan

3 Tan moderately

2 Tan lightly

4 Tan deeply

### Eye colour

**Q14.** What colour are your eyes?

1 Blue

5 Brown

2 Grey

6 Other (*please specify*)

3 Green

4 Hazel

### Hair colour

**Q15.** What was your NATURAL hair colour when you were 21 years of age?

1 Red / Auburn

4 Black

2 Dark brown

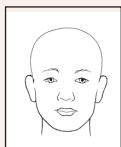
5 Light brown

3 Blonde

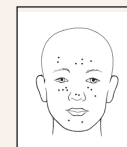
### Freckles

**Q16.** When you were 21 years of age, how many FRECKLES on your face did you have at the end of summer? Match your answers with the pictures below.

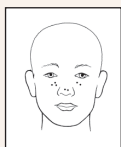
*Please cross one box*



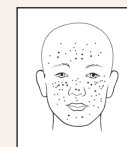
1 I had no freckles



3 I had some freckles



2 I had a few freckles

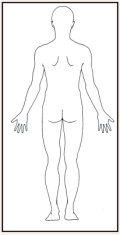


4 I had many freckles

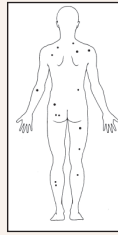
## Moles

Moles are small brown or black spots on the skin, either raised or flat. Moles usually develop before age 20. They do not change in appearance after sun exposure.

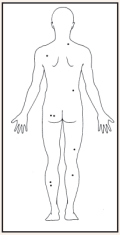
**Q17.** When you were 21 years of age, how many MOLES did you have on your skin? Match your answers with the pictures below. Please cross one box



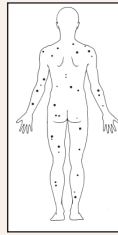
1 I had no moles



3 I had some moles



2 I had a few moles



4 I had many moles

Please count the MOLES on your LEFT UPPER ARM (from shoulder to elbow only) that are larger than this dot (2mm)

(Tip: use a mirror, or ask somebody to help count the moles on your LEFT UPPER ARM)



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How many of those moles are larger than 5 mm? (that is, larger than this dot)



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## Section C. Some questions about sun exposure and sun protection

**Q18.** About how many times were you sunburned so badly that you were sore for at least 2 days, or your skin peeled..

	50+ times	21-50 times	11-20 times	6-10 times	1-5 times	Never
..as a child? (less than 10 years old)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
..as a teenager/youth? (10-20 years old)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
..as an adult? (more than 20 years old)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

**Q19.** Do you ROUTINELY (that is, most days) apply sunscreen, including moisturisers or makeup with a sun protection factor (SPF), regardless of whether or not you are going out in the sun? please cross all that apply

1 Yes – to my face

3 Yes – to other parts of my body

2 Yes – to my hands/forearms

4 No

**Q20.** Thinking about ALL of the times when you were outside in the sun during the past year, about how often did you:

	Never	Less than 50% of the time	More than 50% of the time	All the time
Apply sunscreen? (OTHER THAN moisturisers/makeup with an SPF)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Wear a hat?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

**Q21.** At each of the following ages/time periods, please tell us how many HOURS you typically spent outdoors and in the sun EACH DAY..

.. MONDAY to FRIDAY?

in the past year

aged 10-19 yrs

aged 20-29 yrs

aged 30-39 yrs

.. SATURDAY/SUNDAY?

in the past year

aged 10-19 yrs

aged 20-29 yrs

aged 30-39 yrs

	0-1 hrs	1-2 hrs	2-3 hrs	4+ hrs
in the past year	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
aged 10-19 yrs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
aged 20-29 yrs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
aged 30-39 yrs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
.. SATURDAY/SUNDAY?				
in the past year	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
aged 10-19 yrs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
aged 20-29 yrs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
aged 30-39 yrs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

**Q22.** How many times IN YOUR WHOLE LIFE have you used sunbeds or tanning beds?

Never	1-5	6-10	11-20	21-50	50+
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

How old were you when you first used sunbeds or tanning beds?

years of age OR  1 Not applicable

## Section D. Medical history: you and your family

**Q23.** In general, compared to other people, would you say your health is?

Excellent	Very Good	Good	Fair	Poor
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**Q24.** About how many separate SKIN CANCERS (but not moles or warts) have you ever had CUT OFF your skin?

20+ skin cancers	10-20 skin cancers	2-10 skin cancers	1 skin cancer	None
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

**Q25.** About how many separate SUNSPOTS or SKIN CANCERS have you ever had FROZEN or BURNT OFF your skin?

50+ sunspots	21-50 sunspots	11-20 sunspots	6-10 sunspots	1-5 sunspots	None
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

**Q26.** On average, how often have you taken the following common medications during the PAST YEAR? *cross one box*

	Never	Less than 1/month	Less than 1/week	More than 1/week
<b>PARACETAMOL</b> (such as Panadol, Panamax, Tylenol, Dymadon)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>ASPIRIN</b> (such as Aspro, Disprin, Bex, Vincents, Alka-Seltzer)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>ANTI-INFLAMMATORIES</b> (such as Nurofen, Brufen, Ibuprofen, Indocid, Voltaren)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>CORTICO-STEROID tablets by mouth</b> (such as Cortisone, Hydrocortisone, Prednisolone, Dexamethasone)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

Why did you take CORTICO-STEROID tablets by mouth? (please name the condition)

**Q27.** Have any close blood relatives ever been told that they have **MELANOMA**?

(Melanomas are the most serious form of skin cancers, are usually dark, and are always treated by surgery)

If yes: How many of these relatives?

Yes	No	Don't know
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

a) Parent, brother, sister or child

b) Uncle, aunt, niece, nephew or grand-parent

**Q28.** Compared to other Queenslanders, how likely do you think it is that you will get melanoma at some time in the future?

Highly unlikely	Somewhat unlikely	About the same as other Queenslanders	Somewhat more likely	Highly likely
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

In your opinion, what percentage (number from 0 to 100) reflects your chance of getting melanoma in the future?

 %

### Section E. Some questions about your weight, height and lifestyle

**Q29.** How tall are you?

 cms OR  ft  ins

**Q30.** About how much do you weigh now?

 kg

**Q31.** About how much did you weigh at age 21 years?

 kg

**Q32.** Clothing Size - please complete one of the following:

**for MEN:** What is your trouser size now (waist)?

 cms OR  inches

**for WOMEN:** What is your dress size now?

 Size 

**Q33.** Have you ever been a regular smoker?

(That is, have you ever smoked tobacco daily for at least 6 months?)

Yes	No
<input type="checkbox"/> 1	<input type="checkbox"/> 2 → Go to Q34

How old were you when you started smoking regularly?

 years of age

Are you a regular smoker now?

Yes	No
<input type="checkbox"/> 1	<input type="checkbox"/> 2

if No: How old were you when you stopped smoking regularly?

 years of age

About how much do/did you smoke on average each day?

 Cig/day

**Q34.** How many alcoholic drinks do you usually have each week? (one drink = a glass of wine, pot of beer or nip of spirits)

None	Less than 1	2-4	5-6	7-13	14-20	21-27	28 or more
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8

On how many days each week do you usually drink alcohol? (go to Q35 if you answered 'none' or 'less than 1')

1	2	3	4	5	6	7 days
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

**Q35. How many servings of the following foods do you usually eat each day?**  
*(one serving = a piece of fruit, a 250ml cup of juice, or half a cup of vegetables)*

<b>Fruit</b>	<input type="text"/>	<input type="text"/>	pieces per day
<b>Fruit juice</b>	<input type="text"/>	<input type="text"/>	cups per day
<b>Vegetables</b> <i>(excluding potatoes)</i>	<input type="text"/>	<input type="text"/>	servings per day

**Q36. How many hours of sleep do you usually get each night, on average?**

0-5	6	7	8	9	10+
<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6

**Q37. On a scale of 1 to 10 how would you rate your average level of stress during the PAST YEAR?**  
*(1 means you had little or no stress and 10 means you had a great deal of stress)*

1	2	3	4	5	6	7	8	9	10
<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5	<input type="text"/> 6	<input type="text"/> 7	<input type="text"/> 8	<input type="text"/> 9	<input type="text"/> 10

**Q38. During the past 3 years how many times has ALL or NEARLY ALL of your skin been deliberately checked by ...**

	Never	Once	2-5 times	More than 5 times	Don't remember
<b>...A DOCTOR</b>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
<b>...SOMEONE ELSE</b> <i>(e.g. spouse, partner)</i>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5
<b>...YOURSELF</b>	<input type="text"/> 1	<input type="text"/> 2	<input type="text"/> 3	<input type="text"/> 4	<input type="text"/> 5

**Section F. WOMEN ONLY (men please go to Q45)**

**Q39. How old were you when your periods started?**

<input type="text"/>	<input type="text"/>	years of age
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**Q40. Have you been through menopause?**

Yes	No	
<input type="text"/> 1	<input type="text"/> 2	→ Go to Q42

**If Yes: at what age?**

<input type="text"/>	<input type="text"/>	years of age
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**If Yes: How did your periods stop?**

<input type="checkbox"/> 1 Naturally	<input type="checkbox"/> 3 After a hysterectomy
<input type="checkbox"/> 2 Birth control pill	<input type="checkbox"/> 4 Hormone treatment

**Q41. Have you ever used HORMONE REPLACEMENT THERAPY (HRT) for any reason?** *(For example for menopausal symptoms or osteoporosis) That includes hormone tablets, patches, implants, creams or pessaries.*

Yes	No
<input type="text"/> 1	<input type="text"/> 2

**If Yes: How long did you use HRT for altogether?**

<input type="text"/>	<input type="text"/>	years	<input type="text"/>	<input type="text"/>	months
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**Q42.** Have you ever taken oral contraceptives or used injected contraceptives?

Yes <sub>1</sub> No <sub>2</sub>

*If Yes: for how long?*

years   months

**Q43.** How many children have you given birth to?  
(Please include stillbirths but do not include miscarriages; please write "0" if you have not had any children)

children

**Q44.** Has a doctor ever told you that you have endometriosis?

Yes <sub>1</sub> No <sub>2</sub> Don't know <sub>3</sub>

*If Yes: was it diagnosed by...*

<sub>1</sub> Surgery OR <sub>2</sub> Clinically (i.e. no operation)

### Section G: for MEN and WOMEN

**Q45.** Have you ever been diagnosed with cancer other than skin cancer?

Yes <sub>1</sub> No <sub>2</sub>

*If yes: What type of cancer was it? (Please list up to 2)*

*When was it diagnosed?*

1.

2.

**Q46.** Have you ever been diagnosed with any other serious disease that required treatment from a specialist Doctor?

Yes <sub>1</sub> No <sub>2</sub>

*If yes: What illness was diagnosed? (Please list up to 2)*

*When was it diagnosed?*

1.

2.

**Thank you for completing the survey. Please sign the two consent forms and return them together with the Survey in the envelope provided.**

### FURTHER INFORMATION

If you would like to provide further detail about any of the questions, please use the following space:

Question Number	Comment
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

Alternatively you may contact the Study Team

Phone: 1800 222 600

Fax: (07)3845 3502

Email: [Qskin@qimr.edu.au](mailto:Qskin@qimr.edu.au)



## Q Skin PARTICIPANT CONSENT FORM – PART 1 OF 2

Q Skin relies on Queensland people sharing information about themselves. WE ARE ASKING YOU TO SIGN TWO FORMS. By signing this form (part 1 of 2) you are agreeing to take part in the Q Skin Study and for the Study team to follow your health over time. The second form (on the other side of this page) is required by Medicare Australia. By signing the second form you are agreeing to the release of Medicare information for the purposes of the Q Skin Study. Participation is completely voluntary, and you are free to ask questions or to withdraw from the Study at any time, by calling the Study helpline on 1800 222 600.

**I agree to have my health followed over time through:**

**the Q Skin Study team following health and other records relating to me**, including hospital records, cancer records, death records and other health-related records (such as Medicare Australia), as outlined in the Study information sheet Q Skin: Information for participants;

**being contacted in the future** to provide information on changes to my health and lifestyle. I may also be asked to provide further information including survey responses or biological samples; my participation in any of these would be completely voluntary.

**I give my consent on the understanding that:**

**my information will only be used for the purposes outlined in the Study information sheet** entitled *Q Skin: Information for participants*, of which I have a copy;

**my information will be kept strictly confidential** and will be used for health research only;

**reports and publications from the Study will be based on de-identified information** and will not identify any individual person taking part;

**my participation in this Study is entirely voluntary** and my consent will continue to be valid following death or disablement unless withdrawn by my next of kin or other person responsible. I am free to withdraw from the Study at any time by calling the Study Helpline on 1800 222 600.

**my decision on whether or not to take part** in the Study or in any additional research will not disadvantage me or affect my future health care in any way.

I have been provided with information about the Q Skin Study including how it will gather, store, use and disclose information about me, in the Study information sheet. I have been given an opportunity to ask questions and have been fully informed about the Study.

Signature

Today's date

D	D	M	M	Y	Y	Y	Y
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If you have any questions about the study please contact the Study Helpline on 1800 222 600. If you have any complaints you may contact the Chairman of the QIMR Human Research Ethics Committee by phoning the Secretary, on (07) 3362 0117.

### Contact details

Your home phone no.: (  )   Your mobile no.:

Your postal address: 

Street number and name	Suburb	State	Post Code
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It would be very helpful if we could contact you in future by email. It would also reduce Study costs and our carbon footprint. If you are happy for us to do this, please write your email address below:

Email address:

Sometimes we find that people have moved when we try to contact them again. It would be very helpful if you could give us the contact details of someone close to you (such as a relative or friend) who we could contact if we are unable to reach you. We would only get in touch with that person if we were unable to contact you directly and we would need to tell them our reason for contacting you. Please leave this section blank if you do not wish to provide these extra contact details.

Full name of contact person:

Residential address of contact person: 

Street number and name	Suburb	State	Post Code
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Phone number of contact person: (  )

Email address of contact person:

PLEASE TURN THE PAGE AND COMPLETE THE OTHER SIDE >>

## Q Skin PARTICIPANT CONSENT FORM – PART 2 OF 2

By signing this form you are agreeing to the release of **Medicare and/or Pharmaceutical Benefits Scheme** information for the purposes of the Q Skin Study.

1. I agree to be a Participant in the Q Skin Study.
2. I have been provided with information about this study including how this study will access, store, use and disclose information about me. I have been given an opportunity to ask questions and have been fully informed about this study. I understand that my participation is entirely voluntary and that my participation will not have any effect on my personal dealings with Medicare Australia.
3. My participation in this study will be from the consent/data extraction specified on this form, or to the end of this study.
4. I understand that this study is/may be ongoing, unless I am otherwise notified. In the event that this study exceeds the 10 year maximum period of consent, this study will be required to obtain a new consent form signed by me.
5. I understand that my details on this consent form will be provided to Medicare Australia.
6. I agree to Medicare Australia releasing the specified Medicare and/or Pharmaceutical Benefits Scheme (PBS) claims information about me to the Q Skin Study Team, and understand that this specified information will be collected, stored and analysed only for the purposes of this study.
7. I understand that the specified Medicare and/or PBS claims information about me, released by Medicare Australia to the study, will be stored in secure facilities and accessed only by authorised personnel.
8. I understand that the specified Medicare and/or PBS claims information about me will not be published in a manner that could identify me as an individual, during or after the conclusion of this study.
9. I understand that I can, at any time, withdraw my consent to participate in this study (and to the further release of my Medicare and/or PBS claims information). I understand that the effective date of this notification will be the date on which my withdrawal notice is received by the study, and that information about me collected prior to this date will continue to be used and form part of this study. Should I wish to withdraw my consent, I can do so by calling the study helpline on 1800 222 600. I also understand I may become ineligible should I no longer meet the criteria for the study.
10. I understand that specified information about me collected for the purposes of this study could be stored for a period of at least 10 years after the conclusion of this study, or until the completion of the evaluation of this study, whichever date occurs last. At the end of this period, this information will be destroyed.

Full Name:  Gender:  Male  Female

Medicare card number:  Date of birth:

Residential address:

Contact Phone Number: (  )

**I consent for this study to obtain my Medicare (MBS) and Pharmaceutical Benefits (PBS) claims history. Consent/data extraction valid from today (please fill in the date below) to: 30/09/2020**

Signature

Today's date

**ONLY if participant is unable to sign:**

Signature of witness

Today's date

Full Name of Witness:

Reason Participant is unable to sign:

Relationship to Participant:

**Thank you very much for taking part**

**Barcode**