Salt Sources Study Dietary Recall Scheduling Form

Note to Clinic coordinator: Please complete this form for each participant. Email completed form to Mary Austin at NCC (austi006@umn.edu, peas0027@umn.edu, nuss0018@umn.edu).

Participant ID:_____ Sub Study Non-Sub Study (circle one)

Participant Name:_____ Sex: male female (circle one)
first and last

Recall 1

Date:_____/_____/_____
month date year

Time: _____am/ pm (circle one) CT/ PT (circle one)

Phone number:_____ home/ cell/ work/ other (circle one)

Recall 2

Date:_____/_____/_____
month date year

Time: _____am/ pm (circle one) CT/ PT (circle one)

Phone number:_____ home/ cell/ work/ other (circle one)

Recall 3

Date:_____/_____/_____
month date year

Time: _____am/ pm (circle one) CT/ PT (circle one)

Phone number:_____ home/ cell/ work/ other (circle one)

Recall 4

Date:_____/_____/_____
month date year

Time: _____am/ pm (circle one) CT/ PT (circle one)

Phone number:_____ home/ cell/ work/ other (circle one)

Any special instructions/notes: _____
_____
_____