Asthma Clinical Research Network
BAGS
NIH/NHLBI

ELIGIBILITY CHECKLIST 1

E1

Patient ID: 1 ___ ___ ___ ___
Patient Initials: ___ ___ ___
Visit Number: 0 1
Visit Date: ___ ___ / ___ ___ / ___ ___ (month / day / year)
Interviewer ID: ___ ___ ___ ___

(Patient Interview completed)

01 1. ***Did the patient sign the Informed Consent form?*** ❑1 Yes ■0 No

01A *If **Yes**, record the date the form was signed.* ___ ___ / ___ ___ / ___ ___ *(month / day / year)*

02 2. Are you between the ages of 12 and 55 years inclusive? ❑1 Yes ■0 No

03 3. Do you plan to move more than 75 miles away fom this clinic in the next year? ■1 Yes ❑0 No

04 4. Have you experienced a life-threatening asthma attack requiring treatment with intubation and mechanical ventilation in the past 5 years? ■1 Yes ❑0 No

05 5. Have you had a respiratory tract infection in the past 6 weeks? ■1 Yes ❑0 No

06 6. Have you experienced a significant exacerbation of asthma in the past 6 weeks? ■1 Yes ❑0 No

07 7. ***(☞ Females only)*** Are you potentially able to bear children? ❑1 Yes ❑0 No

07A If ***Yes***, are you using a birth control method indicated on this reference card? (*Show patient the Birth Control Methods reference card.*) ❑1 Yes ■0 No

08 8. Is the patient eligible? ***If any of the shaded boxes are filled in, the patient is NOT eligible.*** ❑1 Yes ❑0 No

☞ If Yes, please continue with the screening process.
☞ If No, please complete the Termination of Study Participation form (TERM).