MULTICENTER STUDY OF HYDROXYUREA IN SICKLE CELL ANEMIA (MSH)

MISSED VISIT

CURCLIN	CLINIC NO.						
ID	I.D. NO.					.	
VISIT	VISIT					.	

Submit Form 22 for any scheduled MSH Visit (QV or FV) which was entirely missed, i.e., the patient was not seen, blood specimens were not collected, and study treatments (for FVs) or folic acid (for QVs) were not dispensed. If blood specimens were obtained OR study treatment was dispensed, complete Form 20 for FVs or Form 02 for QVs; answer all items.

PART I: IDENTIFYING INFORMATION

1. Patient Name Code: ---------------------------------- NAMECODE ___ ___ ___ ___ ___

2. Expected date of this visit: ------------------ ___ ___ - ___ ___ ___ - ___ ___ (VIS-DT)
   Day Month Year

3. Date contact made or attempted: ---------------- ___ ___ - ___ ___ ___ - ___ ___
   Day Month Year

PART II: PATIENT FOLLOW-UP STATUS

4. Were you able to make contact with: WHOCON
   - The patient ---------------------------- (1)
   - Someone else --------------------------- (2)
   - No one --------------------------------- (3)

5. Primary reason patient missed visit: WHYMIS
   - Deceased --------------------------- (01)
     ↓
     Complete Form 45-Death Notification.
   - Hospitalized/Medical Contact --------- (02)
     ↓
     Complete Form 25-Medical Contact.
   - Ill at home ------------------------ (03)
   - Schedule conflict ------------------ (04)
   - Transportation problem ------------- (05)
   - Refusal ---------------------------- (06)
   - Moved ------------------------------ (07)
   - Other ------------------------------ (08)

   Specify: F22RMK ________________________________

   - Unknown ---------------------------- (09)

		Yes	No	Unknown
6. Reportable events since the last completed visit (Answer each item).				
a. Transfusion	TRANSF	(1)	(2)	(3)
b. Placement on a chronic transfuion program	CHTRAN	(1)	(2)	(3)
c. Pregnancy	PREG	(1)	(2)	(3)
7. Has telephone number or best times to contact the patient by telephone changed?	TELCHG	(1)	(2)	(3)
		Yes ↓	No	Unknown

If YES, complete Form 10.

Remind patient of next scheduled appointment and to return bottles and diaries.

8. Checked for completeness and accuracy:

A. Certification Number: CERT_NO __ __ - __ __

B. Signature: ______________________________

Telecopy (FAX) this form to the Data Coordinating Center [410-435-4232] by Friday of the week the patient's visit was expected. Retain this form for your files.

I.D. No. [ ][ ][ ][ ] - [ ]