

**MULTICENTER STUDY OF HYDROXYUREA  
 IN SICKLE CELL ANEMIA (MSH)**

**PATIENT CONTACT FOR TREATMENT STOP ORDER  
 (CENTRAL OFFICE)**

ID  
 VISIT

CLINIC NO.					
PATIENT I.D.					
VISIT	F	V			

VIS

PART I: CENTRAL OFFICE COORDINATOR

To be completed by the Central Office Coordinator

1. Patient's NAME CODE: NAMECODE .....

2. Treatment stop order issued on: A. Date: VIS-PT \_\_\_\_\_  
 Day Month Year

B. Military time: ..... VIS-HR : VIS-MIN

3. Type of stop order: STOP\_F33  
 Two-week stop/conditional restart ..... ( 1 )  
 Temporary stop/wait for restart order (Form 35) ..... ( 2 )  
 Permanent stop/never restart ..... ( 3 )  
 Treatment interruption/wait for resume  
 order (Form 37) or restart order (Form 35) ..... ( 4 )

4. Is Assistant Coordinator directed to contact the patient and  
 instruct him/her to stop taking study medications? ..... ASST-CON ..... ( 1 ) ( 2 )  
 Yes No

5. Part I reviewed for completeness and accuracy by:

Signature: \_\_\_\_\_ Certification Number: CERT-NO \_\_\_\_\_

Telecopy (FAX) this page to Central Office Assistant Coordinator (239-3467), to the Data  
 Coordinating Center (435-4232), and to the patient's Clinical Center at this time.

CLINIC NO.					
PATIENT I.D.					-
PATIENT NAME CODE					
VISIT	F	V			

To be completed by the Central Office Assistant Coordinator.

PART II: CENTRAL OFFICE ASSISTANT COORDINATOR

6. Did the Central Office Assistant Coordinator contact the patient? ----- ( 1 ) ( 2 )  
Yes No  
↓

A. Date ----- Day - Month - Year

B. Military time: ----- : -----

SKIP TO ITEM 8.

A. How many attempts were made to contact the patient? -----

B. Date and time contact attempts ended:

1. Date ----- Day - Month - Year

2. Military time: ----- : -----

SKIP TO ITEM 10.

8. Did the patient agree to stop taking all study treatments? ----- Yes No  
( 1 ) ( 2 )

9. Did the patient agree to return all unused capsules at the next MSH Clinic Visit? ----- ( 1 ) ( 2 )

10. Part II reviewed for completeness and accuracy by:  
Signature: \_\_\_\_\_ Certification Number: \_\_\_\_\_

Please telecopy (FAX) this form to the Data Coordinating Center (435-4232), and telecopy (FAX) it to the respective clinic for this patient. Keep a copy in your files.