MULTICENTER STUDY OF HYDROXYUREA       CLINIC NO.         'N SICKLE CELL ANEMIA (MSH)       IP         Adjective for a patient or essume study treatment (Form 37) is initiated by Central Office staff for a patient who was placed on a Treatment Interruption wait for Resume Order (Form 33, Item 3=4) and the reason for the stop no longer exists.         PART I:       CENTRAL OFFICE         1.       Patient's NAME CODE:         2.       Date of resume treatment order:         VIS-P1       Day         Month       Year         3.       A. Certification Number:         CMF_SIGN         Telecopy (FAX) this form to the Assistant Coordinator (410-239-3467) and to the patient's link.				Draft	Rev	Form 3 0 6/ Page	2	
AESUME TREATMENT ORDER       IV       PATIENT I.D.       I         A directive for a patient to resume study treatment (Form 37) is initiated by Central Office staff for a patient who was placed on a Treatment Interruption wait for Resume Order (Form 33, Item 3=4) and the reason for the stop no longer exists.         PART I:       CENTRAL OFFICE         1.       Patient's NAME CODE:       NAMELODE         2.       Date of resume treatment order:       VS-VI         3.       A.       Certification Number:       CMP_CEPI         B.       Signature:       CMP_SIGN	N SICKLE CELL ANEMIA (MSH)		CLINIC NO.			]		
A directive for a patient to resume study treatment (Form 37) is initiated by Central Office staff for a patient who was placed on a Treatment Interruption wait for Resume Order (Form 33, Item 3=4) and the reason for the stop no longer exists.         PART I: CENTRAL OFFICE         1. Patient's NAME CODE:		IP	PATIENT I.D	.	1		]-	$\square$
for the stop no longer exists.  PART I: CENTRAL OFFICE  1. Patient's NAME CODE:		VISIT	VISIT	F	v			1
1. Patient's NAME CODE:		orm 37) is it r <u>Resume C</u>	nitiated by Centh <u>Irder</u> (Form 33,	ral Offi Item 3	ce sta =4) d	ff for a p and the	natien reaso	ut n
<ol> <li>Date of resume treatment order: <u>VS-P1</u></li> <li>Day Month Year</li> <li>A. Certification Number: <u>CMP_CER1</u></li> <li>B. Signature: <u>(MP_SIGN</u></li> </ol>	PART I: CENTRAL OFFICE							<b>_</b>
Day Month Year 3. A. Certification Number: <u>CMP_CERT</u> B. Signature: <u>(MP_SIGN</u>	1. Patient's NAME CODE: NAMELODE							
3. A. Certification Number: <u>CMP_CERT</u> B. Signature: <u>(MP_SIGN</u>	2. Date of resume treatment order:					_		
B. Signature: <u>(MP_SIGN</u>			Day	Mont	h	Y	ar	
	3. A. Certification Number: CMP_CERT							-
Telecopy (FAX) this form to the Assistant Coordinator (410-239-3467) and to the patient's ) linic.	B. Signature: (MP_SIGN			-	<u> </u>	<b></b> <u>_</u>		
	Telecopy (FAX) this form to the Assistant Coor   linic.	rdinator (	410-239-3467)	and t	o the	e patie	nt's	7
PART II: CENTRAL OFFICE ASSISTANT COORDINATOR	PART II: CENTRAL OFFICE ASSISTANT COORDINATOR			<u> </u>	<u> </u>			]
4. The Assistant Coordinator is to contact the patient and instruct him/her to resume taking study treatment, keep the next scheduled clinic visit and return all study bottles. Attempts to contact the patient should continue until successful or until the patient's next scheduled visit. The result of the attempted contact was:	bottles. Attempts to contact the patient	autea citr	nic visit and	returr	n all			ie .
Patient was contacted and agreed to resume study treatment ( 1)						(	1)	
Patient was not reached before the next scheduled study visit ( 2)	Patient was not reached before th	ne next sc	heduled study	visit		(	2)	
5. Check for completeness and accuracy by:	5. Check for completeness and accuracy by:							
A. Certification Number:COCERT	A. Certification Number: CO-CERT					-		
B. Signature: <u>CO_SIGN</u>	B. Signature: <u>CO_SIGN</u>							

Telecopy (FAX) this form to the patient's clinic and to the Data Coordinating Center (410-435-4232).

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