(Clinic Coordinator completed)

Please indicate the reason(s) for termination of study participation.

01 1. ***(Visit 12 Only)***
Has the patient completed the study? ❑1 Yes ❑0 No
If ***Yes***, proceed to page 2.

02 2. ***(Visits 1 - 4 Only)***
During the run-in period, has the patient experienced a significant asthma exacerbation as defined in the Manual of Operations? ❑1 Yes ❑0 No

03 3. Did the patient have a positive pregnancy test? ❑1 Yes ❑0 No

04 4. Has the patient withdrawn consent? ❑1 Yes ❑0 No

04A If ***Yes***, indicate the **primary** reason.
- ❑1 no longer interested in participating
- ❑2 no longer willing to follow protocol
- ❑3 access to clinic is difficult (location, transportation, parking)
- ❑4 unable to make visits during clinic hours
- ❑5 unable to continue on study due to personal constraints
- ❑6 dissatisfied with lack of asthma control
- ❑7 unable to continue due to medical condition unrelated to asthma
- ❑8 treatment failure
- ❑9 other _____

05 5. ***(Visits 1 - 4 Only)***
Has the patient been deemed ineligible according to any eligibility criteria **other** than those already listed? ❑1 Yes ❑0 No

06 6. Is there any other reason for which the patient will no longer be participating in the study? ❑1 Yes ❑0 No

TERMINATION OF STUDY PARTICIPATION

Patient ID: 1 ___ ___ ___ ___

Last Visit Number: ___ ___

Please complete the following section regardless of the reason for termination of study participation.

I verify that all information collected on the ACRN BAGS data collection forms for this patient is correct to the best of my knowledge and was collected in accordance with the procedures outlined in the ACRN BAGS Protocol and Manual of Operations.

S1

_____

Clinic Coordinator Signature

DT1

___ ___ /___ ___ /___ ___

month day year

S2

_____

Principal Investigator Signature

DT2

___ ___ /___ ___ /___ ___

month day year