CAST

UNBLINDING

Affix Patient I.D. Here

COMPLETE THIS FORM WHENEVER THE DRUG IS UNBLINDED

1 Date drug was unblinded DATE 27 ⎵⎵/⎵⎵/⎵⎵ (mo dy yr)

2 Was the need to unblind reviewed prior to unblinding by a physician who was not treating the patient?
☐ 1 yes ☐ 2 no

STUDY DRUG ASSIGNED

3. ☐ 1 CAST-ENC ☐ 2 CAST-FLEC ☐ 3 CAST-MOR
☐ 1 Dose 1 ☐ 2 Dose 2 ☐ 3 Other: ⎵⎵⎵ mg/day

PERSONS UNBLINDED

4	yes	no	
	☐ 1	☐ 2	Patient
	☐ 1	☐ 2	Patient's private physician
	☐ 1	☐ 2	Surgeon or anesthesiologist
	☐ 1	☐ 2	Physician not treating the patient
	☐ 1	☐ 2	CAST personnel, specify:

Name ______________________ Code No. ⎵⎵⎵

Name ______________________ Code No. ⎵⎵⎵

REASONS FOR UNBLINDING

5	yes	no	
	☐ 1	☐ 2	Demanded by referring physician
	☐ 1	☐ 2	Prior to surgery
	☐ 1	☐ 2	Demanded by patient
	☐ 1	☐ 2	Drug toxicity

specify: ⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵

☐ 1 ☐ 2 Medical treatment (other than surgery)

specify: ⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵

☐ 1 ☐ 2 Other

specify: ⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵⎵

ADDITIONAL DETAILS

6 ⎵⎵

⎵⎵

If opened, return drug code envelope to the Coordinating Center.

Name of person filling out form ______________________ Code Number ⎵⎵⎵