

Clinic Visit Contact Checklist (Administrative)

Patient ID: _____
 Patient Initials: _____
 Clinical Center: _____
 Contact Week: _____
 Date: ____ / ____ / ____
 month day year
 RC ID: _____

(Research Coordinator completed at Clinic visits - weeks 3, 10, 17, 24 and post treatment f/u)

	<u>Completed</u>	If No , Comment:
<u>Complete the following at weeks 3, 10, 17 and 24:</u>		
1. Collect and review completed Voiding Diary (VOID)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. Collect and review Patient Medication Diaries (PTDIARY) Complete Medication Diary Record (DIARYREC) (To be completed after visit)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Administer Standard Visit Inventory form (STVISIT) and Adverse Event/ Serious Adverse Event form (AESAE)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Distribute study medication and complete Study Medication Tracking Log (MEDTRAC) (at weeks 3, 10, 17)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Participant to complete the following forms: Follow-up Symptoms form (FUSYM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
IC Symptom and Problem Index (SYMPROB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
University of Wisconsin Symptom Survey (UNIVWIS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Obtain blood sample for pregnancy test or laboratory values, if indicated	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. Distribute and discuss: Patient Medication Diaries (PTDIARY)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Voiding Diary (VOID) (Both be sent home with participant at weeks 3, 10, 17) (Voiding Diary to be sent home at week 24, if continuing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. Discuss follow-up visit schedule and schedule next clinic visit (at weeks 3, 10,17 and week 24, if continuing)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Clinic Visit Checklist (Administrative)

Clinical Center: ____
RC I.D.: ____

In addition, complete the following at week 24:

	<u>Completed</u>	If No , Comment:
9. Health Status Questionnaire form (SF36)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10. MOS Sexual Functioning Scale (MOS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
11. Symptom Ranking Cards (CARDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
12. Collect blood sample Complete Lab Results form (LAB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
13. Collect urine sample for banking Complete Urine Sample Tracking (UTRAC)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
14. P.I. to perform physical examination (EXAM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
15. Complete Clinical Center Stop Point (STOP)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

Complete the following during post treatment follow-up only (weeks 36, 48, etc.):

1. Collect and review completed Voiding Diary (VOID)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. Administer Standard Visit Inventory form (STVISIT) and Adverse Event/ Serious Adverse Event form (AESAE)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Distribute study medication and complete Study Medication Tracking Log (MEDTRAC)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Participant to complete the following forms:		
Follow-up Symptoms form (FUSYM)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
IC Symptom and Problem Index (SYMPROB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
University of Wisconsin Symptom Survey (UNIVWIS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____