

ICCTG
PROTOCOL #1

Phone Contact
Checklist
(Administrative)

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

(Research Coordinator completed at Phone Contacts - Weeks 1, 2, 3, 6, 14, 20)

Completed

If **No**, Comment:

Complete the following at weeks 1, 2, and 3 only:

1. Run-in Dosage Record (RUNIN)

☐ Yes ☐ No

Complete the following at weeks 1, 2, 3, 6, 14, 20

2. Complete Telephone Contact form (PHONE)

☐ Yes ☐ No

3. Adverse Event/Serious Adverse Event
(AESAE), if applicable.

☐ Yes ☐ No
