CPCRN CHRONIC PROSTATITIS COHORT

Brief Clinic Contact Checklist

Patient ID: 1 ___ ___ ___ ___
Patient Initials: ___ ___ ___
Clinical Center: ___
Contact Month: ___ ___
Date: ___ ___ / ___ ___ / ___ ___
month day year
RC ID: ___ ___ ___ ___

(Research Coordinator Completed)

___ ___ - Month Contact

		Completed		If ***No***, Comment
1.	Mail reminder prior to clinic contact	❑ Yes	❑ No	_____
2.	Administer the Symptom Index (SXIND)	❑ Yes	❑ No	_____
3.	Perform the physical exam and complete the Physical Exam form (EXAM)	❑ Yes	❑ No	_____
4.	Perform the Four Glass Test	❑ Yes	❑ No	_____
5.	Complete Four Glass Test Microscopy form (FGTM)	❑ Yes	❑ No	_____
6.	Interim Health Care form (IHC)	❑ Yes	❑ No	_____
7.	Schedule next contact	❑ Yes	❑ No	_____