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N** CHRONIC  
PROSTATITIS  
COHORT


Deferral Checklist


Patient ID: 1 \_\_\_\_\_  
 Patient Initials: \_\_\_\_\_  
 Clinical Center: \_\_\_\_\_  
 Contact Month: 0  
 Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month                  day                  year  
 RC ID: \_\_\_\_\_

(Research Coordinator Completed)

1. Has the patient been treated with antimicrobial agents (oral or parenteral) in the past three months? <sub>1</sub> Yes <sub>0</sub> No
2. Has the patient had a urinary tract infection with a urine culture value of >100,000 CFU/ml within the past three months? <sub>1</sub> Yes <sub>0</sub> No
3. Has the patient had any of the following sexually transmitted diseases (STDs) in the past three months:
  - 3a. Gonorrhea <sub>1</sub> Yes <sub>0</sub> No
  - 3b. Chlamydia <sub>1</sub> Yes <sub>0</sub> No
  - 3c. Mycoplasma <sub>1</sub> Yes <sub>0</sub> No
  - 3d. Trichomonas <sub>1</sub> Yes <sub>0</sub> No
4. Has the patient had a prostate biopsy in the past three months? <sub>1</sub> Yes <sub>0</sub> No
5. Has the patient experienced symptoms of acute or chronic epididymitis within the past three months? <sub>1</sub> Yes <sub>0</sub> No
6. Has the patient been diagnosed with or treated for symptomatic genital herpes in the past twelve months? <sub>1</sub> Yes <sub>0</sub> No

7. Is the patient eligible for the study at this time? <sub>1</sub> Yes <sub>0</sub> No  
***If any of the shaded boxes are filled in, the patient must be deferred.***

 If **Yes**, please continue with the screening process.

 If **No**, please indicate the date the patient will be eligible.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month                  day                  year