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N** CHRONIC
PROSTATITIS
COHORT

Screening Contact
Checklist

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

(Research Coordinator Completed)

Screening Contact - Visit 1

		Completed		If No , Comment
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
1.	Acquire signed Informed Consent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
2.	Assign Patient ID number	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
3.	Administer the Patient Contact Information form (CONT)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
4.	Inclusion Checklist (INCL)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
5.	Exclusion Checklist (EXCL)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
6.	Deferral Checklist (DEF)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
7.	Administer the Symptom Index (SXIND)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
8.	Medical History form (MED)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
9.	Prior Treatments and Procedures form (PRIOR)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
10.	Perform the physical exam and complete the Physical Exam form (EXAM)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
11.	Perform the Four Glass Test, and send the samples to be cultured.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
12.	Complete Four Glass Test Microscopy form (FGTM)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

Screening Contact Checklist

Patient ID: 1
 Contact Month: 0

- | | | Completed | | If No , Comment |
|-----|---|------------------------------|-----------------------------|------------------------|
| 13. | Complete Four Glass Test Specimen Cultures form (FGTSC) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 14. | Collect the serum sample and complete the Serum Sample form (SERUM) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 15. | Distribute and discuss the Voiding Log (VOID) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 16. | Discuss follow-up visit schedule and schedule screening visit 2. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

Screening Contact - Visit 2

- | | | | | |
|-----|---|------------------------------|-----------------------------|-------|
| 17. | Collect completed Voiding Log (VOID) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 18. | Concomitant Medications form (CMED) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 19. | Administer the Epidemiologic History form (EPI) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 20. | Perform uroflow and complete the Uroflow Study form (URO) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 21. | Perform the urethral swab and send the sample to be cultured. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 22. | Complete the Urethral Swab form (SWAB) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 23. | Collect the semen sample and send the sample to be cultured. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 24. | Complete the Semen Sample form (SEMEN) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 25. | Schedule the One Month Phone Contact | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| 26. | Screening Confirmation form (SCR) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |