C P C R N	CHRONIC PROSTATITIS COHORT	Telephone 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 and the Symptom Index (SXIND) prior to call	❑ Yes	❑ No	______________
2.	Receive Symptom Index (SXIND) in the mail	❑ Yes	❑ No	______________
3.	Schedule next contact	❑ Yes	❑ No	______________