CRISP

Follow-Up Study and Events Form

CRISP -FORM # 13

Missing Codes:
A-Participant refused
B-Reading not possible
C-Investigator forgot

Use Missing Codes to indicate reason for absent information.

This form is to be completed for participant's 3-month follow-up, additional physician, or hospital visits.

1. **Date of Contact**: _____ / _____ / _____ DVDATE
   Month Day Year

2a. Type of Event (circle one)**:** scheduled follow-up visit SAE adverse events other events TOE

2b. Mode of Contact (circle one)**:** office telephone fax email unknown MOC

3. **Has the participant had any illnesses since last study contact (**circle one): yes no ILYN

   If yes, please specify: _____ ILL _____

   _____

   _____

4. **Has the participant visited their primary care or any other physician since last study contact (**circle one): yes no PVYN

   If the response is yes, then record 4a-c,g. Use 4d-f for additional visit (If 4e is identical to 4b, then enter SAME for Name in 4e)**:**

   4a. Date of physician visit: _____ / _____ / _____ PVDATE **Check if there are multiple visits of this type:** MVC1
   Month Day Year

   4b. Name and address of physician treating participant: Name: _____ PVNME _____

   Address:_____ PVADDS _____

   4c. Specify reason for visit: _____ PVREASON _____

   4d. Date of additional physician visit: _____ PV2DATE _____ **Check if there are multiple visits of this type:** MVC2
   Month Day Year

   4e. Name and address of physician treating participant: Name: _____ PV2NME _____

   Address:_____ PV2ADD _____

   4f. Specify reason for visit: _____ PV2REASON _____

   4g. Was there any renal surgery performed? yes no RSURGPYN

   If yes, was the intent cyst reduction: yes no CREDUCYN

   For any renal surgery provide a date and short description:

   Date of intervention: _____ RSIDATE _____ **Description:** _____ RSIDESC _____
   Month Day Year

5. **Has the participant been hospitalized since the last study contact (**circle one)**:** yes no HVYN

   If the response is yes, then record the following 5(a-f)**:**

   5a. Date admitted to hospital: _____ / _____ / _____ HADATE
   Month Day Year

5b. Date discharged from hospital: _____ / _____ / _____ HDDATE
Month Day Year

5c. Name and address of hospital: Name:_____ HNME _____

Address: _____ HADDS _____

5d. Name and address of physician treating participant: Name:_____ PHNME _____

Address:_____ PHADDS _____

5e. What was the diagnosis? _____ HDIAG _____

5f. If this hospitalization was unplanned, has it been reported to the local IRB? Yes No NA AEYN
(NA means this is **not** an SAE**)**

6. Prescribed medications changes:

6a. Have prescribed drugs been added (circle one**)**: yes no PAYN

If yes, then please record:

#	Prescribed Medications **added** PMA1 - PMA5	Date (month, day, year)
		DPMADATE1 -
		DPMADATE5
		/ /
		/ /
		/ /

6b. Have prescribed drugs been stopped/discontinued (circle one**)**: yes no PDYN

If yes, then please record:

#	Prescribed Medications **discontinued** PMD1 - PMD5	Date (month, day, year)
		DPMDDATE1 -
		DPMDDATE5
		/ /
		/ /
		/ /

7. Over-the-counter medications changes:

7a. Have OTC drugs been added (circle one): yes no OAYN

If yes, then please record:

#	OTC Medications **added** OMA1 - OMA5	Date (month,day, year)
		DOMADATE1 -
		DOMADATE5
		/ /
		/ /
		/ /

7b. Have OTC drugs been stopped/discontinued (circle one): yes no ODYN

If yes, then please record:

#	OTC Medications **discontinued** OMD1 - OMD5	Date (month day, year)
		DOMDDATE1 -
		DOMDDATE5
		/ /
		/ /
		/ /

8. Comments: _____ COMMENT _____

_____

_____

CRISP Member completing this form_____ CMIDNUM _____ Date form completed: _____ / _____ / _____ CDDATE
Month Day Year

Contents of Form Reviewed by Principal Investigator (required signature): _____

Date Principal Investigator signed: _____ / _____ / _____ RSDATE
Month Day Year

Data Entry Status: Please check to indicate that the above information has been entered ☐

Data Entry Person _____ DEIDNUM _____ Date Form Entered: _____ / _____ / _____ DEDATE
Month Day Year