FORM254
FSGS Novel Therapies (FONT II)
Semi-Annual Follow-up Starting with Month 24 (Form # 254)

1. Participant ID Number	2. Alpha Code	3. Visit Number	4. Date of Visit (dd/mmm/yyyy)
PID	ALPHCD	CPEVENT / VISIT_NUMBER / SUBEVENT_NUMBER	VISDT

F263.3 a. Has the participant died since their last visit? ....(0 = no, 1 = yes)___DTHNY

b. Date of death.................... (dd/mmm/yyyy) ___ ___/___ ___ ___/___ ___ ___ ___DTHDT

F263.4a. Primary cause of death	MDVT1, MDCLLT1
F263.4b. Secondary cause of death	MDVT2, MDCLLT2

5. a. Does the participant have kidney failure? ....(0 = no, 1 = yes) ___ESRD

b. If yes, patient's ESRD treatment modality .... ___ESRDRX
   1 = hemodialysis
   2 = peritoneal dialysis
   3 = kidney transplant
   4 = untreated (refusing dialysis)
   8 = not applicable
   9 = unknown

c. Date of ESRD onset.......... (dd/mmm/yyyy) ___ ___/___ ___ ___/___ ___ ___ ___ESRDDT

6. a. Has the participant been pregnant since the last visit? ....(0 = no, 1 = yes, 8 = not applicable) ___PREG1

b. Is the participant currently pregnant? ....(0 = no, 1 = yes, 8 = not applicable) ___PREG2

7. a. Since the last visit has an SAE or hospitalization related to the
   study medication occurred? ....(0 = no, 1 = yes) ___EVENT1

b. Date of event?.............. (dd/mmm/yyyy) ___ ___/___ ___ ___/___ ___ ___ ___EVENTDT1

c. Diagnosis? ...._____EVENTDX1

Since the participant's last visit, did any of the following occur?

8. a. Cardiovascular event?..(0 = no, 1 = yes) ___EVENT2

b. Date of event?.............. (dd/mmm/yyyy) ___ ___/___ ___ ___/___ ___ ___ ___EVENTDT2

c. Diagnosis? ...._____EVENTDX2

FAX COMPLETED FORM TO FONT STUDY DESK
UMich (734) 232-2353   NYU (212) 263-4053

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Since the participant's last visit, did any of the following occur, continued…

9. a. Thromboembolic event? ....(0 = no, 1 = yes) ___EVENT3

    b. Date of event?.............. (dd/mmm/yyyy) ___ ___/___ ___ ___/___ ___ ___ ___EVENTDT3

    c. Diagnosis? ...._____EVENTDX3

10. a. Malignancy? ....(0 = no, 1 = yes) ___EVENT4

    b. Date of event?.............. (dd/mmm/yyyy) ___ ___/___ ___ ___/___ ___ ___ ___EVENTDT4

    c. Diagnosis? ...._____EVENTDX4

11. a. Infection with hospitalization? ....(0 = no, 1 = yes) ___EVENT5

    b. Date of event?.............. (dd/mmm/yyyy) ___ ___/___ ___ ___/___ ___ ___ ___EVENTDT5

    c. Diagnosis? ...._____EVENTDX5

12. Is the participant currently involved in another clinical trial?....................................... (0=no, 1=yes, 9=unknown)___OTHTRL

200. Date this form completed......................(dd/mmm/yyyy) ___ ___ /___ ___ ___ /___ ___ ___ ___

201. Username of person completing this form...........................___ ___ ___ ___ ___ ___ ___ ___