

HEMO Study Form 40. Inability to Communicate Form

FAX this to the DCC before data entry

This form is completed when the Clinical Center becomes aware that a patient will no longer be able to answer questions due to a cognitive or medical reason. Do not complete this form if a patient briefly loses the ability to communicate, but the ability is expected to return.

- 1. Patient Identification Number..... _____
- 2. Patient Name Code _____
- 3. Date of onset of inability to communicate..... __/__/____
(If the date is unknown and in the past, tell us the month and year and fill in 01 for the day).

“I verify that the patient cannot communicate.”

Signature of HEMO Principal Investigator _____

201. Date this form completed..... __/__/____

202. Certification number of person completing this form _____

Clinical Center Use Only	
Data Form Entered __/__/____	Verified? _____
Person Entering This Form _____	