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 PROTOCOL #1

Phone Contact
 Checklist
 (Administrative)

Patient ID: _____
 Patient Initials: _____
 Clinical Center: _____
 Contact Week: _____
 Date: ____ / ____ / ____
 month day year
 RC ID: _____

(Research Coordinator completed at Phone Contacts - Weeks 1, 2, 3, 6, 14, 20)

Completed If **No**, Comment:

Complete the following at weeks 1, 2, and 3 only:

1. Run-in Dosage Record (RUNIN) Yes No _____

Complete the following at weeks 1, 2, 3, 6, 14, 20

2. Complete Telephone Contact form (PHONE) Yes No _____

3. Adverse Event/Serious Adverse Event
 (AESAE), if applicable. Yes No _____