ICDB

Patient ID: ___ ___ ___ ___ ___ ___

Interstitial Cystitis Data Base

I hereby verify that all information collected on the ICDB data collection forms for this patient is correct to the best of my knowledge and that this patient is eligible to be enrolled in the ICDB Study Database according to all inclusion, exclusion and deferral criteria defined in the ICDB Protocol.

Research Coordinator:

Please indicate last screening phase visit date: ___ ___ / ___ ___ / ___ ___

_____

(*Research Coordinator Signature*) (*Date)*

Principal Investigator:

Does this patient have the "IC complex"?

- ☐$_4$ definitely
- ☐$_3$ very likely
- ☐$_2$ possibly
- ☐$_1$ not very likely
- ☐$_0$ definitely not

_____

(*Principal Investigator Signature)* *(Date)*