Off Protocol

Patient ID __ __ - __ __ __ __ - __ __ __

Date form completed *(mm/dd/yy):* ___ /___ /___

Instructions: Complete this form to report a deviation from protocol, at the time that the occurrence becomes known.

Protocol Deviation (check one):

1 ☐ Ineligible patient enrolled

2 ☐ Follow-Up evaluation not completed in-person, specify reason _____

Time-point: 1 ☐ 8 Week 2 ☐ 6 Month 3 ☐ 12 Month

Method of follow-up (check all that apply): ☐ Telephone ☐ Medical record

☐ PCP ☐ Other _____