PEDS-C
Death Report

1042

Please Use Black Pen To Fill Out Form.

Week # week

Date of Assessment assessdt mm / dd / yyyy

Patient ID idn - -

Patient Letter Code letcode

corrfix ○ Correction

1. Date of death: dthdt mm / dd / yyyy

2. Location of death (Choose one) dthloc
   - ○ At home
   - ○ Hospital in-patient
   - ○ Other

3.A. Was an adverse event reported to the Clinical Center IRB? ○ Yes ○ No dthae

   B. If **Yes**, date adverse event reported: dthaedt mm / dd / yyyy

4.A. Is the primary cause of death known? ○ Yes ○ No dthcaus1

   B. If **Yes**, what was the primary cause of death? (from the Death Certificate or other source):

_____

5.A. Is the secondary cause of death known? ○ Yes ○ No dthcaus2

   B. If **Yes**, what was the secondary cause of death? (from the Death Certificate or other source):

_____

6. Was the death attributable to the study drug therapy? (Choose one answer): dthstddrg
   - ○ Definitely
   - ○ Unlikely
   - ○ Probably
   - ○ Definitely not
   - ○ Possibly
   - ○ Unknown

CRA Use Only

Complete a Withdrawal/Close-Out Form

Signature: _____ **Certif. #:** staffid1 -