

PEDS-C

Long Term Follow Up Assessment  
Annual Visit

PDC 76  
Rev 0  
07/19/2005  
Page 1 of 5

64037

Please Use Black Pen To Fill Out Form.

corrfix  
Correction

Week # <b>week</b>	Annual Visit <input type="radio"/> 1 <input type="radio"/> 2 <b>avnum</b>	Date of Assessment <b>assesdtd</b>	Patient ID <b>idn</b>	Patient Letter Code <b>letcode</b>
		mm / dd / yyyy	- - -	

Instructions

Use this form for patients in *all therapy groups* at Annual Visits 1 and 2.

1.A. Is the patient willing and able to continue in the study?

Yes  No **avptcnt**

B. If No, date of the Withdrawal/Close-out Form:

**avwddt** / mm / dd / yyyy

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Only

Vital Signs

2.A. Temperature:

**avtmp** . C

2.B. Site:

Oral  Tympanic  Axillary  Unable to obtain  **avtmpst**

3. Blood Pressure:

A. Systolic

**avsysbp** mmHg

B. Diastolic

**avdiabp** mmHg

Unable to obtain  **avbpna**

4. Pulse:

**avpuls** bpm

Unable to obtain  **avpulna**

Physical Exam

5. Indicate if each body area is within normal limits. If No, specify or comment.

1. Yes No NA 2. Specify / Comment

A. Head, eyes, ears:

**avhead**

B. Nose, mouth, throat:

**avnose**

C. Neck:

**avneck**

D. Chest (including breasts, axillae):

**avchst**

E. Genitalia, groin, buttocks:

**avgntl**

F. Abdomen:

**avabdm**

G. Each extremity:

**avextm**

H. Back, including spine:

**avback**

I. Skin:

**avskin**

Signature: \_\_\_\_\_

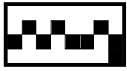
Certif. #: \_\_\_\_\_

**staffid1** - [ ] [ ] [ ] [ ] [ ] [ ]

PEDS-C

Long Term Follow Up Assessment  
Annual Visit

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21165

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Physical Exam (Continued)

6. Indicate if each organ system is within normal limits. If **No**, specify or comment.

1. Yes No NA 2. Specify

- A. Neurologic:    *avneur*
- B. Psychologic:    *avpsyc*
- C. Genitourinary:    *avgnto*
- D. Hematologic / Lymphatic:    *avhmto*
- E. Allergies / Immunologic:    *avallr*
- F. Musculoskeletal:    *avmusc*
- G. Other:    *avothog*

CRA Use Only

7.A. Was the patient referred to another health professional?  Yes  No *avrefr*

If **No**, skip to item 8.

B. Reason for referral: \_\_\_\_\_

C. Date of referral:  /  /  *avrefdt*

D. Name of health professional: \_\_\_\_\_

8. Is the patient a sexually active female at least 10 years old or a sexually active male?  Yes  No *avsexat*

If **No**, skip to item 10.

9. Indicate all types of contraception used (Answer each item):

- |   | Yes                   | No                    |                |
|---|-----------------------|-----------------------|----------------|
| A. Oral contraceptive                           | <input type="radio"/> | <input type="radio"/> | <i>avcnora</i> |
| B. Intrauterine contraceptive device            | <input type="radio"/> | <input type="radio"/> | <i>avcniud</i> |
| C. Depot contraceptives (implants, injectables) | <input type="radio"/> | <input type="radio"/> | <i>avcndep</i> |
| D. Physical barrier (condom, diaphragm)         | <input type="radio"/> | <input type="radio"/> | <i>avcnphy</i> |
| E. Abstinence                                   | <input type="radio"/> | <input type="radio"/> | <i>avcnabs</i> |
| F. None   | <input type="radio"/> | <input type="radio"/> | <i>avcnnon</i> |
| G. Other  | <input type="radio"/> | <input type="radio"/> | <i>avcnoth</i> |

Specify *avcnosp*

Signature: \_\_\_\_\_

Certif. #: *staffid2*



46500

# PEDS-C Long Term Follow Up Assessment Annual Visit

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Week # <i>week</i>	Annual Visit <input type="radio"/> 1 <i>avnum</i> <input type="radio"/> 2	Date of Assessment <i>assessdt</i> mm / dd / yyyy	Patient ID <i>idn</i>	Patient Letter Code <i>letcode</i>
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## Anthropometry

A. First measurement	B. Second measurement	C. Unable to measure
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10. Height:	<i>avht1</i> [ ] [ ] . [ ] cm	<i>avht2</i> [ ] [ ] . [ ] cm	<input type="radio"/> <i>avhtna</i>
11. Weight:	<i>avwt1</i> [ ] [ ] . [ ] kg	<i>avwt2</i> [ ] [ ] . [ ] kg	<input type="radio"/> <i>avwtna</i>
12. Mid-arm circumference (right):	<i>avarm1</i> [ ] [ ] . [ ] cm	<i>avarm2</i> [ ] [ ] . [ ] cm	<input type="radio"/> <i>avarmna</i>
13. Biceps skinfold (right):	<i>avbskn1</i> [ ] [ ] . [ ] mm	<i>avbskn2</i> [ ] [ ] . [ ] mm	<input type="radio"/> <i>avbsknna</i>
14. Triceps skinfold (right):	<i>avtskn1</i> [ ] [ ] . [ ] mm	<i>avtskn2</i> [ ] [ ] . [ ] mm	<input type="radio"/> <i>avtsknna</i>
15. Subscapular skinfold (right):	<i>avsskn1</i> [ ] [ ] . [ ] mm	<i>avsskn2</i> [ ] [ ] . [ ] mm	<input type="radio"/> <i>avssknna</i>
16. Iliac skinfold (right):	<i>aviskn1</i> [ ] [ ] . [ ] mm	<i>aviskn2</i> [ ] [ ] . [ ] mm	<input type="radio"/> <i>avisknna</i>
17.A. Has a DXA scan been performed?	<input type="radio"/> Yes <input type="radio"/> No <i>avdxa</i>		
B. If Yes, date of scan:	<i>avdxadt</i> / [ ] [ ] / [ ] [ ] [ ] [ ] mm dd yyyy		
18.A. Has a Bio-electrical Impedance Analysis been performed?	<input type="radio"/> Yes <input type="radio"/> No <i>avbia</i>		
B. If Yes, date of BIA:	<i>avbiadt</i> / [ ] [ ] / [ ] [ ] [ ] [ ] mm dd yyyy		
19.A. Has the parent / patient been given the 3-day food diary?	<input type="radio"/> Yes <input type="radio"/> No <i>avfdry</i>		
B. If Yes, date of first diary day:	<i>avfdrdt</i> / [ ] [ ] / [ ] [ ] [ ] [ ] mm dd yyyy		
20.A. Has the Physical Activity Assessment been completed?	<input type="radio"/> Yes <input type="radio"/> No <i>avpact</i>		
B. If Yes, date completed:	<i>avpacdt</i> / [ ] [ ] / [ ] [ ] [ ] [ ] mm dd yyyy		

Signature: \_\_\_\_\_

Certif. #: *staffid3* [ ] [ ] - [ ] [ ] [ ] [ ]

Long Term Follow Up Assessment  
Annual Visit

47814

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Week # <b>week</b>	Annual Visit <b>avnum</b>	Date of Assessment <b>assessdt</b>	Patient ID <b>idn</b>	Patient Letter Code <b>letcode</b>
<input type="text"/>	<input type="radio"/> 1 <input type="radio"/> 2	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/>
		mm dd yyyy		

Concurrent Medications and Conditions

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21.A. Ask the parent (or patient) the following question:

Has your child (have you) had any other problems since your last visit?

Yes  No **avptprb**

If No, skip to item 22.

B. Was a Serious Adverse Event Form completed?

Yes  No **avsae**

C. If Yes, date of the SAE form:

**avsaedt** /  /

D. Was a Non-Serious Adverse Event Form completed?

Yes  No **avae**

E. If Yes, date of the AE form:

**avaedt** /  /

22.A. Ask the parent (or patient) the following question:

Has your child (have you) taken any new medicines, other than those given to you within this study, since the last visit?

Yes  No **avnwmed**

If No, skip to item 23.

B. Has the Concurrent Medications Form been completed?

Yes  No **avmeds**

C. If Yes, date of the form:

**avmstdt** /  /

Depression Screen

23.A. Was the patient's raw score greater than 19 on the CDI or greater than 15 on the CES-D?

Yes  No **avcdi19**

If No, skip to item 24.

B. If Yes, was the patient referred for depression management according to Protocol requirements?

Yes  No **avrefdp**

If No, skip to item 24.

If Yes, continue drug therapy and begin a Depression Management Tracking Form.

Signature: \_\_\_\_\_

Certif. #: \_\_\_\_\_

**staffid4** -

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Correction

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List of Laboratory Tests Ordered at Annual Visit

	Done	Unable to obtain
24.A. Hematology:	<input type="radio"/>	<input type="radio"/> <i>a48hmtst</i>
B. PT / PTT:	<input type="radio"/>	<input type="radio"/> <i>a48ptst</i>
C. Chemistry:	<input type="radio"/>	<input type="radio"/> <i>a48chmst</i>
D. HCV-RNA (Clinical):	<input type="radio"/>	<input type="radio"/> <i>a48vlcst</i>
E. Thyroid function:	<input type="radio"/>	<input type="radio"/> <i>a48thyst</i>
F. Serum bank:	<input type="radio"/>	<input type="radio"/> <i>a48serbk</i>
G. Urinalysis:	<input type="radio"/>	<input type="radio"/> <i>a48urnst</i>

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Quality of Life Tests Administered at Annual Visit

Test Name	1. Completed		2. Form date			3. Completed by	
	Yes	No	mm	dd	yyyy	Patient	Parent
25.A. CHQ (Patient)	<input checked="" type="radio"/> <i>avcht</i>	<input type="radio"/>	<i>avchtdt</i>	/	/	<i>avchtby</i>	<input type="radio"/>
B. CHQ (Parent)	<input checked="" type="radio"/> <i>avchr</i>	<input type="radio"/>	<i>avchrdt</i>	/	/	<i>avchrby</i>	<input type="radio"/>
C. BRIEF (Parent)	<input checked="" type="radio"/> <i>avbrf</i>	<input type="radio"/>	<i>avbrfdt</i>	/	/	<i>avbrfby</i>	<input type="radio"/>
D. CBCL (Parent)	<input checked="" type="radio"/> <i>avcbc</i>	<input type="radio"/>	<i>avcbcdt</i>	/	/	<i>avcbcby</i>	<input type="radio"/>
E. ABCL (Parent)	<input checked="" type="radio"/> <i>avabc</i>	<input type="radio"/>	<i>avabcdt</i>	/	/	<i>avabcby</i>	<input type="radio"/>
F. LEC (Parent)	<input checked="" type="radio"/> <i>avlec</i>	<input type="radio"/>	<i>avlecdt</i>	/	/	<i>avlecby</i>	<input type="radio"/>
G. SF-36 (Parent)	<input checked="" type="radio"/> <i>avs36</i>	<input type="radio"/>	<i>avs36dt</i>	/	/	<i>avs36by</i>	<input type="radio"/>

Signature: \_\_\_\_\_

Certif. #:

*staffid5* - [ ] [ ] [ ] [ ]