Steroid trial	BARC	Form S22-2wk F/U Diet / Meds

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date of visit: ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year) A3. Study Staff ID/Initials: ___ ___ ___

A4. 2 Week Follow-up Visit   To DCC ☐

A5. *This form is to be completed by interview with a subject's parent(s) or guardian(s). Please indicate below the primary source of information for this form (check all that apply):*

a. ☐ Mother SDMA05AM V2(2)   b. ☐ Father SDMA05BF V2(2)   c. ☐ Guardian(s) SDMA05CG V2(2)

d. ☐ OtherSDMA05DO V2(2) (Specify:SDMLA05DS V2(300)___________)   e. ☐ Medical Record SDMA05MR V2(2)

SECTION B: DIET

B1. What do you feed your child *(check all that apply)*?:

Feeding Type	**Specify *(check all that apply)*:**
a. ☐ Human milk SDMB01AM V2(2)	ai. ☐ Breast milk SDMB01AI V2(2) aii. ☐ Banked milk SDMB1AII V2(2)
b. ☐ Cow's milk based formula SDMB01BC V2(2)	bi. ☐ Standard infant formula SDMB01BI V2(2) bii. ☐ Follow-on formula SDMB1BII V2(2)
c. ☐ Cow's milk SDMB01CC V2(2)	ci. ☐ Whole SDMB01CI V2(2) cii. ☐ 2% SDMB1CII V2(2) ciii. ☐ Skim SDMBCIII V2(2)
d. ☐ Soy formula SDMB01DS V2(2)	di. ☐ Prosobee SDMB01DI V2(2) dii. ☐ Isomil SDMB1DII V2(2) diii. ☐ SDMBDIII V2(2) Other_ SDMBIIIS V2(300)___________________
e. ☐ Specialized formula SDMB01ES V2(2)	ei. ☐ Alimentum SDMB01EI V2(2) eii. ☐ Pregestimil SDMB1EII V2(2) eiii.☐ Neocate SDMBEIII V2(2) eiv. ☐ Low lactose SDMB1EIV V2(2) ev. ☐ Nutramigen SDMB01EV V2(2) evi. ☐ Other SDMB1EVI V2(2) SDMBEVIS V2(300)
f. ☐ Parenteral nutrition SDMB01FP 2(2)	fi. ☐ Total SDMB01FI V2(2) fii. ☐ Partial SDMB1FII V2(2)
g. ☐ Solid food SDMB01GS V2(2)	
h. ☐ Not specified SDMB01HN V2(2)	

B2. How is your child fed *(check all that apply)*?

a. ☐ Oral SDMB02AO V2(2)

b. ☐ Nasogastric SDMB02BN V2(2)

c. ☐ Nasoenteric SDMB02CN V2(2)

d. ☐ Gastrostomy SDMB02DG V2(2)

e. ☐ Gastrojejunostomy SDMB02EG V2(2)

f. ☐ Jejunostomy SDMB02FJ V2(2)

g. ☐ Intravenous SDMB02GI V2(2)

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date of visit: ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year) A3. Study Staff ID/Initials: ___ ___ ___

A4. 2 Week Follow-up Visit To DCC ☐

h. ☐ Not specified SDMB02HN V2(2)

B3. How much milk or formula is your child fed per day (you may exclude breast milk from the calculation):

a. SDMB03OZ V2(10) ___ ___ oz/day 8.☐ NA if only breast fed 9.☐ Unknown SDMB03HM V2(2)

b. SDMB03BK V2(10) Kcal/oz formula 9.☐ Unknown SDMB03BU V2(2)

A1. Site/Study ID #: ___ ___ / ___ ___ ___ ___ A2. Date of visit: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

C0. The parent/guardian brought in the subject's medications for review 1. ☐ No 2. ☐ Yes

SECTION C: VITAMINS AND DIETARY SUPPLEMENTS – *DO NOT REPORT VITAMINS PRESCRIBED IN P004

C1. Other than the study-provided medications, does your child take or have they taken any other **vitamins or supplements** since discharge from the hospital?

1. ☐ No → **Go to D1** 2. ☐ Yes SDMC01ME V2(2)

Vitamin/Supplement
a. SDMC01AV V2(300)
b. SDMC01BV V2(300)
c. SDMC01CV V2(300)
d. SDMC01DV V2(300)

SECTION D: OTHER PRESCRIPTION MEDICATIONS — *DO NOT REPORT MEDICATIONS PRESCRIBED IN P004

D1. Other than the study-provided medications, does your child take or have they taken any other **prescription medications** since discharge from the hospital?

1. ☐ No → **END** 2. ☐ Yes SDMD06A0 V2(2)

Medication
a. SDMD01AP V2(300)
b. SDMD01BP V2(300)
c. SDMD01CP V2(300)
d. SDMD01DP V2(300)
e. SDMD01EP V2(300)
f. SDMD01FP V2(300)
g. SDMD01GP V2(300)
h. SDMD01HP V2(300)
i. SDMD01IP V2(300)

SDMCMMNT V2(800) Comment 2