

TELEPHONE REVIEW

PATIENT ID:

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INITIALS

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DATE:

D	D	M	M	Y	Y	Y	Y
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TIME:

H	H	M	M
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STUDY DAY:

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ARM: Single / Control    Reviewing Doctor: \_\_\_\_\_

1. a. Has the patient died?

Yes     No

b. If yes, date of death:

				2	0	1	
dd		mm		yyyy			

c. If date of death unknown, last known alive:

				2	0	1	
dd		mm		yyyy			

2. Date and study day of last study follow-up

				2	0	1	
dd		mm		yyyy			

Study day: 

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COMMENTS:

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