



STOP-ACEi

CRF05 – ADDITIONAL HOSPITAL ADMISSIONS

Form to be completed when a participant's hospital admissions cannot fit on one 3-monthly visit CRF or telephone follow-up CRF. Please use one form for each hospital admission and use as many forms as necessary to record all hospital admissions.

Name of person that completed CRF, please print: This person must be listed on the STOP-ACEi delegation log.										
Date CRF completed:	<table style="border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table>	D	D	/	M	M	/	Y	Y	Y	Y
D	D	/	M	M	/	Y	Y	Y	Y		

Part A: Identifying Details

Trial No.: <table style="border: none;"><tr><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td></tr></table>					Centre:															
DOB: <table style="border: none;"><tr><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td></tr></table>	M	M	M	/	Y	Y	Y	Y	Assessment date: <table style="border: none;"><tr><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td><td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td></tr></table>	D	D	/	M	M	M	/	Y	Y	Y	Y
M	M	M	/	Y	Y	Y	Y													
D	D	/	M	M	M	/	Y	Y	Y	Y										

Part B: Assessment point

Trial visit			
Please indicate which trial visit this entry relates to. Please select one option. Please select the <u>next</u> trial visit after the admission. E.g. if a participant is admitted between visits 8 and 9, please select visit 9.			
<input type="checkbox"/> Visit 2 (month 3)	<input type="checkbox"/> Visit 3 (month 6)	<input type="checkbox"/> Visit 4 (month 9)	<input type="checkbox"/> Visit 5 (month 12)
<input type="checkbox"/> Visit 6 (month 15)	<input type="checkbox"/> Visit 7 (month 18)	<input type="checkbox"/> Visit 8 (month 21)	<input type="checkbox"/> Visit 9 (month 24)
<input type="checkbox"/> Visit 10 (month 27)	<input type="checkbox"/> Visit 11 (month 30)	<input type="checkbox"/> Visit 12 (month 33)	<input type="checkbox"/> Visit 13 (month 36)

Part H: Clinical visits

Hospital admissions												
Please provide the details of the hospital admission below. Please record the details of any related AEs or changes to medications in the AE and Medications sections of the relevant visit CRF. If any clinical visit relates to a serious adverse event, please also report it within 24 hours of notification using CRF10: SAE form.												
Date admitted:	<table style="border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		
Have they been discharged? No <input type="checkbox"/> Yes <input type="checkbox"/> - If yes, date:	<table style="border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">D</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 20px; height: 20px; text-align: center;">Y</td> </tr> </table>	D	D	/	M	M	M	/	Y	Y	Y	Y
D	D	/	M	M	M	/	Y	Y	Y	Y		
Was the visit related to the participant's CKD? No <input type="checkbox"/> Yes <input type="checkbox"/>												
Main reason for admission:												
Treatment given:	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Prescription medicine** <input type="checkbox"/></td> <td style="width: 50%;">Advice to buy OTC medication** <input type="checkbox"/></td> </tr> <tr> <td>Advice <input type="checkbox"/></td> <td>Referral to a specialist <input type="checkbox"/></td> </tr> <tr> <td colspan="2">Other <input type="checkbox"/>, specify:</td> </tr> </table>	Prescription medicine** <input type="checkbox"/>	Advice to buy OTC medication** <input type="checkbox"/>	Advice <input type="checkbox"/>	Referral to a specialist <input type="checkbox"/>	Other <input type="checkbox"/> , specify:						
Prescription medicine** <input type="checkbox"/>	Advice to buy OTC medication** <input type="checkbox"/>											
Advice <input type="checkbox"/>	Referral to a specialist <input type="checkbox"/>											
Other <input type="checkbox"/> , specify:												
** Please note any new medications or changes to existing medications in the medications section of the relevant visit CRF.												

Thank you for completing the STOP-ACEi CRF05: Additional Hospital Admissions

Please enter data online at: <https://www.trials.bham.ac.uk/STOPACEi>

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