



Early Rib Analgesia with SERratus: ERASER Trial
 A Pragmatic Randomised Control Trial Evaluating the Clinical and Cost-Effectiveness of
 Serratus Anterior Plane Block with Catheter Insertion compared to Usual Care in Patients
 with Multiple Rib Fractures

DISCHARGE FORM

This trial uses eCRF only and all data should be entered onto <https://bctu-redcap.bham.ac.uk>. This form illustrates the data that should be collected on the **day that the participant is discharged from hospital**.

Section 1 - PARTICIPANT DETAILS

Trial no: <input type="text"/>	Partial date of birth: <i>e.g. Jan2017</i> <input type="text"/>	Site ID: <input type="text"/>
Date Today: <input type="text"/>	Has the patient had a SAP catheter inserted during ERASER? <input type="radio"/> Yes* <input type="radio"/> No	

***If Yes, please answer the following questions**

Site of SAP catheter insertion:	<input type="radio"/> Left <input type="radio"/> Right <input type="radio"/> Bilateral	
Was the SAP catheter inserted today? <input type="radio"/> Yes - enter date/time <input type="radio"/> No - inserted previously	Date of insertion: <input type="text"/>	Time of insertion: <input type="text"/>
Was the SAP catheter removed today?	<input type="radio"/> Yes - enter date/time <input type="radio"/> No - in place <input type="radio"/> No - Removed previously	
Date of removal: <input type="text"/>	Time of removal: <input type="text"/>	
Did the patient receive the SAP block as part of the treatment arm that they were randomised to:	<input type="radio"/> Yes - randomised to SAP arm <input type="radio"/> No - randomised to usual care arm	

***If No, please complete a change of status form**

Has the participant had any single shot ESP blocks since randomisation?	<input type="radio"/> No <input type="radio"/> Yes - please provide details	
How many single shot ESP blocks has the participant received since randomisation?	<input type="text"/>	
Has the participant had an ESP block via continuous infusion (catheter) since randomisation? (<i>e.g. ESP, PVC, Epidural</i>)	<input type="radio"/> No <input type="radio"/> Yes - please provide details	
Start Date: <input type="text"/>	End Date: <input type="text"/>	Or tick here if dates unknown: <input type="checkbox"/>
Has the participant had a PVC block via continuous infusion (catheter) since admission?	<input type="radio"/> No <input type="radio"/> Yes - please provide details	
Start Date: <input type="text"/>	End Date: <input type="text"/>	Or tick here if dates unknown: <input type="checkbox"/>
Has the participant had a thoracic epidural since randomisation? (<i>e.g. ESP, PVC, Epidural</i>)	<input type="radio"/> No <input type="radio"/> Yes - please provide details	
Start Date: <input type="text"/>	End Date: <input type="text"/>	Or tick here if dates unknown: <input type="checkbox"/>
Has the participant had any other form of regional anaesthesia via continuous infusion since randomisation?	<input type="radio"/> No <input type="radio"/> Yes - please provide details	
If 'other', please specify: <input type="text"/>		
Start Date: <input type="text"/>	End Date: <input type="text"/>	Or tick here if dates unknown: <input type="checkbox"/>

Section 2 - ADMISSION DETAILS

Level of care throughout admission:

Please outline where the patient was located throughout the duration of their admission: *Select all that apply:*

- L0 care
 L1 care
 L2 critical care
 L2 critical care but eligible for L0/L1
 L3 critical care
 L3 critical care but eligible for L0/L1

Please outline the number of days that the participant was located in L0 care: ____ Days

Please outline the number of days that the participant was located in L1 care: ____ Days

Please outline the number of days that the participant was located in L2 critical care: ____ Days

Please outline the number of days that the participant was located in L2 critical care but eligible for L0/L1: ____ Days

Please outline the number of days that the participant was located in L3 critical care: ____ Days

Please outline the number of days that the participant was located in L3 critical care but eligible for L0/L1: ____ Days

Pneumonia diagnosis:

Was the patient diagnosed with Pneumonia by a clinician during their admission? *Select one:*

- No
 Yes - Please confirm the date of diagnosis and the antibiotics that have been prescribed

Date of Pneumonia diagnosis:

M	M	M	Y	Y	Y	Y
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If the patient has been diagnosed with pneumonia, please outline which antibiotics have been prescribed: *Select all that apply:*

- Amoxicillin
 Doxycycline
 Clarithromycin
 Erythromycin
 Co-amoxiclav
 Levofloxacin
 Other

If Other, please specify:

Supplementary oxygen:

Was the patient on supplementary oxygen during their admission:

- No
 Yes - please provide details

Total number of days on supplementary oxygen: _____

How was supplementary oxygen delivered? *Select all that apply:*

- Nasal cannula
 Face mask
 Venturi
 Non-rebreather mask
 High Flow Nasal Oxygen (HFNO)
 CPAP - 5 cmH₂O
 CPAP - 10 cmH₂O
 CPAP - 15 cmH₂O
 Mechanical ventilation

Please outline the number of days that the participant received each type of supplementary oxygen:

Section 3 - PARTICIPANT DISCHARGE DETAILS

Date of Patient Discharge:

D	D	M	M	M	Y	Y	Y	Y
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Time of Patient Discharge:

H	H	M	M
---	---	---	---

Destination following discharge: *Select one:*

- Home (without further care/therapy)
 Home (with outpatient/community care therapy)
 Home (with live-in homecare)
 Inpatient facility
 Hospice
 Nursing home

Section 4 - DISCHARGE ASSESSMENTS

Daily analgesic medication at discharge:

Is the patient taking paracetamol: *Select one*

- No
 Yes - please provide details

Dose: _____

Units: _____

Tick here if daily dose unknown:

Start Date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

Or tick here if date unknown: Is the patient taking Codeine: *Select one*

- No
 Yes - please provide details

Dose: _____

Units: _____

Tick here if daily dose unknown:

Start Date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

Or tick here if date unknown: Is the patient taking Gabapentin: *Select one*

- No
 Yes - please provide details

Dose: _____

Units: _____

Tick here if daily dose unknown:

Start Date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

Or tick here if date unknown:

Is the patient taking Pregabalin: *Select one* No Yes - please provide details

Dose: _____	Units: _____	Tick here if daily dose unknown: <input type="checkbox"/>	Start Date: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y	Or tick here if date unknown: <input type="checkbox"/>
D	D	M	M	M	Y	Y	Y	Y					

Is the patient taking Ketamine: *Select one* No Yes - please provide details

Dose: _____	Units: _____	Tick here if daily dose unknown: <input type="checkbox"/>	Start Date: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y	Tick here if daily dose unknown: <input type="checkbox"/>
D	D	M	M	M	Y	Y	Y	Y					

Is the patient taking NSAIDs: *Select one* No Yes - please provide details

Dose: _____	Units: _____	Tick here if daily dose unknown: <input type="checkbox"/>	Start Date: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y	Or tick here if date unknown: <input type="checkbox"/>
D	D	M	M	M	Y	Y	Y	Y					

Is the patient taking Tramadol: *Select one* No Yes - please provide details

Dose: _____	Units: _____	Tick here if daily dose unknown: <input type="checkbox"/>	Start Date: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y	Or tick here if date unknown: <input type="checkbox"/>
D	D	M	M	M	Y	Y	Y	Y					

Is the patient taking other analgesic medication: *Select one* No Yes - please provide details

Dose: _____	Units: _____	Tick here if daily dose unknown: <input type="checkbox"/>	Start Date: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y	Or tick here if date unknown: <input type="checkbox"/>
D	D	M	M	M	Y	Y	Y	Y					

Was the participant on Morphine during their admission: Yes NoIf Yes, what type of morphine was administered: *Select all that apply:* Morphine PCA Intermittent IV / nurse controlled Morphine Oral Morphine Other

Dose: _____	Units: _____	Tick here if daily dose unknown: <input type="checkbox"/>	Start Date: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y	Or tick here if date unknown: <input type="checkbox"/>
D	D	M	M	M	Y	Y	Y	Y					

Please outline the number of days that the participant was administered each type of morphine:
_____**Lung Function**Incentive spirometry: (ml) _____ Tick if not available:**Visual Analog Scale: Participant Pain Rating**

Please ask the participant to rate their pain at discharge and mark this on the scale below to the nearest 0.5

0	1	2	3	4	5	6	7	8	9	10
no pain										extreme pain

Time of assessment:

24 hr clock e.g. 1400

H	H	M	M
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Tick here if participant is not awake and unable to provide an answer *e.g. if sedated or asleep* **Expected serious adverse events**Did the participant experience any protocol defined expected SAE's during their admission: No Yes - please provide expected SAE ID

Expected SAE ID: _____

Details of SAE: _____

Note: The list of expected SAE's and their ID's can be found in section 10.4.2 of the trial protocol**Section 5 - COMPLETED BY**

The person completing this form must have been delegated the role of data collection on the trial Site and Signature Delegation Log.

This section is completed by: <i>name</i> _____	Signature: _____	Date of signature: <i>e.g. 31Jan2017</i> <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y			