STOP II TRIAL

NON-NEUROLOGICAL EVENT FORM

AFFIX PATIENT LABEL HERE

INSTRUCTIONS

COMPLETE THIS FORM WHENEVER THE PATIENT IS SEEN IN THE EMERGENCY ROOM OR CLINIC OR IS HOSPITALIZED FOR A CLINICAL EVENT WHICH IS NOT A STROKE, TIA, SEIZURE, OR DELAYED TRANSFUSION REACTION.
A SEPARATE EVENT FORM SHOULD BE COMPLETED FOR EACH EVENT TYPE.

IF THE PATIENT IS SEEN FOR A SUSPECTED STROKE, TIA, OR SEIZURES, COMPLETE THE NEUROLOGICAL EVENT FORM.

IF THE PATIENT IS SEEN FOR A DELAYED TRANSFUSION REACTION, COMPLETE THE DELAYED TRANSFUSION REACTION FORM.

A1. Person completing form (Name): _____ (Initials): | | | |

A2. Date form completed (Month/Day/Year): ___ ___/___ ___/___ ___ ___ ___

A3. Date of event (Month/Day/Year): ___ ___/___ ___/___ ___ ___ ___

A4. Event name (see choices below):_____ | | | |
OFFICE USE

OFFICE USE | | | | . | |

OFFICE USE | | | | . | |

Code	Type of Event	Code	Type of Event	Code	Type of Event
010	**Vasoocclusive Pain**	061	**Splenic Sequestration**	111	**New Aseptic Necrosis, Shoulder**
020	**Acute Chest Syndrome (with new pulmonary infiltrate)**	062	**Aplastic Crisis**	120	**Urinary Tract Infection**
030	**Fever without source**	063	**Other anemia (SPECIFY TYPE)**	121	**Hematuria**
041	**Sepsis**	070	**Cholecystitis or cholelithiasis**	122	**Proteinuria**
042	**Meningitis**	080	**Priapism**	123	**Renal Insufficiency**
043	**Osteomyelitis**	090	**Surgery (SPECIFY TYPE)**	124	**Other Renal Complication (SPECIFY TYPE)**
044	**Other Infection (SPECIFY TYPE)**	100	**New Leg Ulcer**	130	**Head Injury with loss of consciousness**
060	**Acute Anemia (unspecified)**	110	**New Aseptic Necrosis, Hip**	160	**Other event (SPECIFY TYPE)**

A5. Has the patient been seen for the same type of event within the week preceding this visit?

☐ **1. NO** ☐ **2. YES →**

A5.a Do the present history, symptoms, and/or physical exam indicate that this event is a continuation of the previous event?

☐ **1. NO** ☐ **2. YES** ☐ **9. DK**

☐ ML ☐ DE

A6. Was the patient admitted to the hospital ***because of this event***?

☐ **1. NO** ☐ **2. YES →**

A6.a Date of hospital admission (Month/Day/Year) ___ ___/___ ___/___ ___ ___ ___

A6.b Date of hospital discharge (Month/Day/Year) ___ ___/___ ___/___ ___ ___ ___

B. LABORATORY STUDIES FOR SUSPECTED INFECTIONS

B1. Were samples for any cultures obtained? ☐ **1. NO** ☐ **2. YES**

B1.a CULTURE	**B1.b RESULTS** 1. NEGATIVE	2. POSITIVE	**B1.c SPECIFY ORGANISM**
1. _____ →	☐	☐ → _____	☐☐☐☐ OFFICE USE
2. _____ →	☐	☐ → _____	☐☐☐☐ OFFICE USE
3. _____ →	☐	☐ → _____	☐☐☐☐ OFFICE USE
4. _____ →	☐	☐ → _____	☐☐☐☐ OFFICE USE

B2. Were any serological studies performed? ☐ **1. NO** ☐ **2. YES**

B2.a. Were the results of any of these studies positive? ☐ **1. NO** ☐ **2. YES**

B2.b. Were any of the results indicative of an **<u>acute</u>** infection?

☐ **1. NO** ☐ **2. YES** ☐ **3. DON'T KNOW**

B2.b1 What was the infectious agent?_____

B2.b2 What was the evidence that this was an acute infection?

_____

_____

_____

C. MANAGEMENT AND COMPLICATIONS

C1. Were there other events associated with this event? ☐ **1. NO** ☐ **2. YES**

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COMPLETE SEPARATE EVENT FORM FOR EACH EVENT TYPE

C2. Did the patient require ventilator support? ☐ **1. NO** ☐ **2. YES**

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C2.a Number of days ☐☐

C3. Was the patient transfused for this event? ☐ **1. NO** ☐ **2. YES**

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COMPLETE TRANSFUSION FORMS

C4. Did patient die as a result of this event? ☐ **1. NO** ☐ **2. YES**

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COMPLETE CAUSE OF DEATH FORM

IF THIS FORM IS BEING COMPLETED FOR EITHER A MENINGITIS OR A HEAD INJURY EVENT, AN MRI AND NEUROLOGICAL EXAMINATION BY THE STOP NEUROLOGICAL CONSULTANT MUST BE PERFORMED 3-4 WEEKS AFTER HOSPITAL DISCHARGE. FORMS 14 AND 15 MUST BE COMPLETED AT THAT TIME.

Signature of Study Coordinator: _____ Date: ___ ___/___ ___/___ ___ ___ ___