

MSH Patients' Follow Up - Extension I
Form 50 - Patient Event

Instructions

1. The date the event(s) occurred or began should be recorded in the identifying information box. This date should fall in the Annual Visit window indicated in the identifying information box.
2. At AV06, all reportable events occurring from Feb 2002 should be reported.
3. The items listed on the form are the reportable events for MSH patients. These include death (any cause), stroke, renal failure, hepatic failure, cancer, sepsis or other serious infection, birth of a child or termination of pregnancy. All events occurring concurrently should be reported together.
4. Attachments must be provided that adequately document the nature of the event. These may include discharge summaries, death certificate, doctor's notes, emergency room notes, progress notes, psychologist's notes, laboratory slips, surgical reports, reports of diagnostic or therapeutic procedures, etc. Attachment pages completed on both sides are counted as two pages.

Event	Date	Time	Room	Unit	Patient	Room	Time	Date		
									A	V

Report together on one Form 50 all of the following events occurring concurrently or as a direct consequence of each other. Report separate events, according to occurrence, on separate Form 50.

Event	Yes	No
A. Death DEAD	<input type="checkbox"/> 1	<input type="checkbox"/> 2
B. Stroke STROKE	<input type="checkbox"/> 1	<input type="checkbox"/> 2
C. Renal failure REN-FAIL	<input type="checkbox"/> 1	<input type="checkbox"/> 2
D. Hepatic failure HEP-FAIL	<input type="checkbox"/> 1	<input type="checkbox"/> 2
E. Cancer CANCER	<input type="checkbox"/> 1	<input type="checkbox"/> 2
F. Sepsis or other serious infection SEPS-INF	<input type="checkbox"/> 1	<input type="checkbox"/> 2
G. Live birth LIVE-BTH	<input type="checkbox"/> 1	<input type="checkbox"/> 2
H. Stillbirth/miscarriage/abortion PREG-TRM	<input type="checkbox"/> 1	<input type="checkbox"/> 2

Total pages of documentation F50-P61S
 or description attached

Requested by: _____	_____
Date: _____	_____

Retain a copy of this form for your files. Send the original to the Medical Coordinating Center, Maryland Medical Research Institute, 600 Wyndhurst Avenue, Baltimore, Maryland 21210. By FAX transmission to 410/435-4232. Thank you.

_____	_____	_____	_____
A	V	_____	_____