

PATIENT'S FOLLOW UP EXTENSION		DATE		MONTH		YEAR	
NAME		LAST		FIRST		MIDDLE	
ADDRESS		CITY		STATE		ZIP	
PHONE		FAX		E-MAIL		A V	

PATIENT'S VITAL STATUS	YSTAT66		
	(1) Alive	(2) Dead	(3) Unknown
A. If DEAD, date patient died	DTMM-DD		
B. If DEAD, please submit Form 50	(1) Form 50 HAS been submitted (2) Form 50 WILL BE submitted FMSDMIT		
C. If ALIVE or UNKNOWN, date patient last known alive to you	ALIVE DT		
D. If ALIVE or UNKNOWN, please indicate patient's status	(1) Has moved to another area (2) Refuses participation (3) Detailed explanation attached PSTAT66		
E. If UNKNOWN, please indicate your preference for conducting a person search	(1) Clinical center staff will conduct search (2) Medical Coordinating Center staff are requested to conduct search SEARCH		

* If day is unknown, use 01; if month is unknown, use JUN.

HYDROXYUREA USAGE HISTORY through date of death or last seen alive	(1) Form 44 HAS BEEN completed & submitted (2) Form 44 WILL BE completed & submitted (3) Explanation Attached HWHISTRY
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PATIENT'S CONTACT INFORMATION		DATE		MONTH		YEAR	
NAME		CITY		STATE		ZIP	
PHONE		FAX		E-MAIL		A V	

tain 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.