Patient Details:

Patient's full name: Sex: Male ☐ Female ☐

Date of birth: / / Hospital number:

Responsible clinician: Hospital:

PD REHAB trial number:

AE Description:

Date event started: ...../...../..... Date event ceased: ...../...../.....

Outcome: Fatal ☐ Recovered ☐ Continuing ☐

Details of adverse event: .....

.....

.....

.....

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Did the event require hospitalisation? No ☐ Yes ☐ No of days ☐

Reason why you consider event to be intervention related: .....

.....

.....

.....

Name of person reporting: .....

Telephone Number: .....

Date: ...../...../.....