[redacted]

# AVURT PRESCRIPTION

*EudraCT number: 2014-003979-39* *CI:* [redacted]

**Patient Name:** _____ **Date of Birth:** ____/____/____
(Please Print) (DD/MON/YYYY)

**Screening ID:** _____ **Site ID:** _____

**Drug Allergy:** **Yes/ No** If YES, please specify: _____
(Please Circle)

**Preferred Delivery Address** (Please Print):

_____

_____ Post-Code __ __ __ __ __ __ __

**Preferred Delivery Days/Times** (Please circle one or all that apply):

Monday Tuesday Wednesday Thursday Friday AM or PM or Both

**Ulcer Size:** _____ $cm^2$

Please dispense the following:

**ASPIRIN 300mg or PLACEBO capsule**

Take ONE capsule ONCE a day with or after food for 24 weeks

**Prescriber Signature:** _____ **Date:** _____
(As per Delegation Log)
**Print Name:** _____

*Please retain a copy of the prescription, then fax to* [redacted] *before sending the original to:*
Research Pharmacy [redacted].

**For Pharmacy use only**

**Patient Trial Number**_____ **Bottle Number**_____

**Dispensed By:** _____ **Date:** _____

**Checked By:** _____ **Date:** _____

**AVURT spread-sheet** – info added to 'YORK – AVURT subject update' [redacted]