Site ID: | | Date (DD/MM/YY): | | | | | | Participant ID Number: | | | |

AVURT

Aspirin for Venous Ulcers: Randomised Trial

Participant medication diary
COVER SHEET

For Participant
and
study investigator Completion

Site ID: [ ][ ] Screening ID: [ ][ ][ ][ ][ ] Participant ID Number: [ ][ ][ ]

AVURT
Participant Diary- Change in Medication

Baseline Medications – to be filled in with the research nurse at baseline visit

Name of Medication | **Reason Taking**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year		Day	Month	Year		Ongoing?
First Dose				**Last Dose**				or	

Name of Medication | **Reason Taking**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year		Day	Month	Year		Ongoing?
First Dose				**Last Dose**				or	

Name of Medication | **Reason Taking**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year		Day	Month	Year		Ongoing?
First Dose				**Last Dose**				or	

Baseline medications continued

Name of Medication **Reason Taking**

How much do you take? **How often do you take it?** **Total number of doses daily?**

First Dose Day Month Year **Last Dose** Day Month Year or **Ongoing?**

Name of Medication **Reason Taking**

How much do you take? **How often do you take it?** **Total number of doses daily?**

First Dose Day Month Year **Last Dose** Day Month Year or **Ongoing?**

Name of Medication **Reason Taking**

How much do you take? **How often do you take it?** **Total number of doses daily?**

First Dose Day Month Year **Last Dose** Day Month Year or **Ongoing?**

Site ID: ☐☐ Screening ID: ☐☐☐☐☐ Participant ID Number: ☐☐☐

Baseline medications continued

Name of Medication | **Reason Taking**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

First Dose Day Month Year | **Last Dose** Day Month Year **or** **Ongoing?**

Name of Medication | **Reason Taking**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

First Dose Day Month Year | **Last Dose** Day Month Year **or** **Ongoing?**

Name of Medication | **Reason Taking**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

First Dose Day Month Year | **Last Dose** Day Month Year **or** **Ongoing?**

Baseline medication

This section to be completed by your nurse or research nurse

_______________________________________ ____________________

Signature of nurse completing baseline meds Date baseline meds entered

Site ID: | | Screening ID: | | | | | | Participant ID Number: | | | |

Changes to Medication

Please record any consistent changes that you or your doctor or nurse make to any of the current medications that you take. Please also record new medications prescribed. You do not need to record if you accidently miss a dose or if you take a different dose on a single occasion.

Name of Medication | **Reason Taking (or reason for change)**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year		Day	Month	Year	Ongoing?
First Dose				**Last Dose**				or

This section to be completed by your nurse or research nurse

_____ Signature of person reviewing change

_____ Date reviewed

Name of Medication | **Reason Taking (or reason for change)**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year		Day	Month	Year	Ongoing?
First Dose				**Last Dose**				or

This section to be completed by your nurse or research nurse

_____ Signature of person reviewing change

_____ Date reviewed

Site ID: ☐☐ Screening ID: ☐☐☐☐☐ Participant ID Number: ☐☐☐

Name of Medication | **Reason Taking (or reason for change)**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year		Day	Month	Year	Ongoing?
First Dose	☐☐	☐☐	☐☐	**Last Dose**	☐☐	☐☐	☐☐	**or** ☐

This section to be completed by your nurse or research nurse

_____ _____

Signature of person reviewing change | Date reviewed

Name of Medication | **Reason Taking (or reason for change)**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year		Day	Month	Year	Ongoing?
First Dose	☐☐	☐☐	☐☐	**Last Dose**	☐☐	☐☐	☐☐	**or** ☐

This section to be completed by your nurse or research nurse

_____ _____

Signature of person reviewing change | Date reviewed

Site ID: ☐☐ Screening ID: ☐☐☐☐☐ Participant ID Number: ☐☐☐

Name of Medication | **Reason Taking (or reason for change)**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year	Day	Month	Year	Ongoing?
First Dose	☐☐	☐☐	☐☐				
Last Dose	☐☐	☐☐	☐☐				or ☐

This section to be completed by your nurse or research nurse

_____ _____

Signature of person reviewing change | Date reviewed

Name of Medication | **Reason Taking (or reason for change)**

How much do you take? | **How often do you take it?** | **Total number of doses daily?**

	Day	Month	Year	Day	Month	Year	Ongoing?
First Dose	☐☐	☐☐	☐☐				
Last Dose	☐☐	☐☐	☐☐				or ☐

This section to be completed by your nurse or research nurse

_____ _____

Signature of person reviewing change | Date reviewed