ARREST

Emergency CRF: RU Enrolment

Centre No.:	*Centre Name:*		
Patient Trial ID No.:	*Patient Date of Birth:*	*Patient Initials:*	*Date of Assessment:*

Resource Utilisation (RU)

Was the patient admitted to an intensive therapy unit (ITU) at any time after the date of the first positive blood culture? ☐Yes ☐No

If yes, give date of admission to ITU: ____/___/_____

If yes, has the patient been discharged from ITU? ☐Yes ☐No

If yes, give date of discharge from ITU: ____/___/_____

Was the patient admitted to a high dependency unit (HDU) at any time after the date of the first positive blood culture? ☐Yes ☐No

If yes, give date of admission to HDU: ____/___/_____

If yes, has the patient been discharged from HDU? ☐Yes ☐No

If yes, give date of discharge from HDU: ____/___/_____

Investigations

Were any investigations performed on this patient whilst being treated for this episode of *S. aureus* bacteraemia? ☐Yes ☐No

☐ Ultrasound scan (other than echocardiogram)	Performed _____ times
☐ CT Scan	Performed _____ times
☐ MRI Scan	Performed _____ times
☐ PET Scan	Performed _____ times
☐ PET CT Scan	Performed _____ times
☐ Bone Scan	Performed _____ times
☐ White cell scan	Performed _____ times
☐ Other (please specify): _____	Performed _____ times

Were any procedures performed on this patient whilst being treated for this episode of *S. aureus* bacteraemia? ☐Yes ☐No

☐ Radiologically guided biopsy/aspriate/abcess drainage	Performed _____ times
☐ Surgical drainage/removal of non-device related focus requiring general or spinal anaesthesia	Performed _____ times
☐ Surgical removal of infected prosthetic device requiring general or spinal anaesthesia	Performed _____ times
☐ Cardiac surgery for *S. aureus* endocarditis	Performed _____ times
☐ Other procedure Please specify: _____	Performed _____ times

Completed by: (Print name)	*Signature:*	*Date: (dd/mm/yyyy)*

ARREST

Emergency CRF: RU Enrolment

Please return completed CRF to the ARREST Team within **48 hours** of completion by fax to [redacted]

ARREST

Emergency CRF: RU Follow-up

Centre No.:	*Centre Name:*		
Patient Trial ID No.:	*Patient Date of Birth:*	*Patient Hospital No.:*	*Date of Assessment:*

Resource Utilisation (RU)

Was the patient admitted to an intensive therapy unit (ITU) at any time since the last study visit? ☐Yes ☐No

If yes, give date of admission to ITU: ____/___/_____

If yes, has the patient been discharged from ITU? ☐Yes ☐No

If yes, give date of discharge from ITU: ____/___/_____

Was the patient discharged from a previously reported admission to ITU? ☐Yes ☐No

If yes, give date of discharge from ITU: ____/___/_____

Was the patient admitted to a high dependency unit (HDU) at any time since the last study visit? ☐Yes ☐No

If yes, give date: ____/___/_____

If yes, has the patient been discharged from HDU? ☐Yes ☐No

If yes, give date: ____/___/_____

Was the patient discharged from a previously reported admission to HDU? ☐Yes ☐No

If yes, give date: ____/___/_____

Investigations

Have any new investigations been performed on this patient whilst being treated for this episode of *S. aureus* bacteraemia (i.e. since the last study visit)? ☐Yes ☐No

☐ Ultrasound scan (other than echocardiogram)	Performed _____ times
☐ CT Scan	Performed _____ times
☐ MRI Scan	Performed _____ times
☐ PET Scan	Performed _____ times
☐ PET CT Scan	Performed _____ times
☐ Bone Scan	Performed _____ times
☐ White cell scan	Performed _____ times
☐ Other (please specify): _____	Performed _____ times

Have any new procedures been performed on this patient whilst being treated for this episode of *S. aureus* bacteraemia (i.e. since the last study visit)? ☐Yes ☐No

☐ Radiologically guided biopsy/aspriate/abcess drainage	Performed _____ times
☐ Surgical drainage/removal of non-device related focus requiring general or spinal anaesthesia	Performed _____ times
☐ Surgical removal of infected prosthetic device requiring general or spinal anaesthesia	Performed _____ times
☐Cardiac surgery for S. aureus endocarditis	Performed _____ times
☐Other procedure – please describe: _____	Performed _____ times

ARREST

Emergency CRF: RU Follow-up

Centre No.:	*Centre Name:*		
Patient Trial ID No.:	*Patient Date of Birth:*	*Patient Hospital No.:*	*Date of Assessment:*

Completed by: (Print name)	*Signature:*	*Date: (dd/mm/yyyy)*

Return completed CRF to the ARREST Team within **48 hours** of completion by fax to [redacted]

ARREST

Emergency CRF: RU Follow-up

Centre No.:	Centre Name:		
Patient Trial ID No.:	**Patient Date of Birth:**	**Patient Hospital No.:**	**Date of Assessment:**

Resource Utilisation (RU) (print more pages if required)

After discharge from hospital, has the patient been seen by their GP? ☐Yes ☐No

If yes, how many GP visits were related to *S. aureus* infection or side effects of infection treatment? ____

If yes, how many GP visits were unrelated to infection? _________________

After discharge from hospital, has the patient been seen in any other hospital out-patient clinic? ☐Yes ☐No

If yes, how many visits to an out-patient clinic were related to *S. aureus* infection or side effects of infection treatment? ________________________________

If yes, how many visits to an out-patient clinic were unrelated to infection? ________

After discharge from hospital following treatment for the bacteraemia, has the patient been admitted to hospital? ☐Yes ☐No

If yes, record below the hospital admissions without staying overnight:

Reason for admission	Procedures undertaken (mark one)
☐related to the infection or related to the side effects of the infection treatment ☐unrelated to infection	☐None ☐CT scan ☐MRI scan ☐PET scan ☐Bone scan ☐Echocardiogram ☐Day-surgery
☐related to the infection or related to the side effects of the infection treatment ☐unrelated to infection	☐None ☐CT scan ☐MRI scan ☐PET scan ☐Bone scan ☐Echocardiogram ☐Day-surgery
☐related to the infection or related to the side effects of the infection treatment ☐unrelated to infection	☐None ☐CT scan ☐MRI scan ☐PET scan ☐Bone scan ☐Echocardiogram ☐Day-surgery

If yes, record below the hospital admissions as an inpatient:

Reason for admission	No. nights in hospital	No. nights in ITU	No. nights in HDU	Procedures undertaken (mark one)
☐related to the infection or related to the side effects of the infection treatment ☐unrelated to infection				☐None ☐CT scan ☐MRI scan ☐PET scan ☐Bone scan ☐Echocardiogram ☐Surgery requiring general or spinal anaesthesia ☐ Other, please describe: _________________
☐related to the infection or related to the side effects of the infection treatment ☐unrelated to infection				☐None ☐CT scan ☐MRI scan ☐PET scan ☐Bone scan ☐Echocardiogram ☐Surgery requiring general or spinal anaesthesia ☐ Other, please describe: _________________
☐related to the infection or related to the side effects of the infection treatment ☐unrelated to infection				☐None ☐CT scan ☐MRI scan ☐PET scan ☐Bone scan ☐Echocardiogram ☐Surgery requiring general or spinal anaesthesia ☐ Other, please describe: _________________

Completed by: (Print name)	Signature:	Date: (dd/mm/yyyy)

ARREST

Emergency CRF: RU Follow-up

Centre No.:	*Centre Name:*		
Patient Trial ID No.:	*Patient Date of Birth:*	*Patient Hospital No.:*	*Date of Assessment:*

Return completed CRF to the ARREST Team within **48 hours** of completion by fax to [redacted]