Report Supplementary Material 19 Adverse Event Review Form

UK FROST: Adverse Event Review Form

Please ensure that this form does not contain patient identifiable details.

Participant ID number: ☐☐☐☐

Research Nurse to complete details of the initial event this review relates to:

Date of initial event ☐☐ / ☐☐ / 2 0 ☐☐ (day / month / year)

Was event classed as a serious adverse event? ☐ Yes ☐ No

Date of this review ☐☐ / ☐☐ / 2 0 ☐☐ (day / month / year)

Please report additional action taken and any further information since initial report:

Is this event now resolved? ☐ Yes ☐ No

Name of PI or delegated clinician completing review

Signature of PI or delegated clinician completing review

Date ☐☐ / ☐☐ / 2 0 ☐☐ (day / month / year)

Please fax to York Trials Unit on 01904 321387

For York Use Only

Date reviewed by TMG ☐☐ / ☐☐ / 2 0 ☐☐ (day / month / year)

Date reviewed by TSC ☐☐ / ☐☐ / 2 0 ☐☐ (day / month / year)

Date reviewed by DMEC ☐☐ / ☐☐ / 2 0 ☐☐ (day / month / year)