Patient ID: _ _ _ **Patient Initials: _ _ _**

Patient Date of Birth: _ _/_ _/_ _ **Allocation Group: Intervention/Control**

Date form completed: _ _/_ _/_ _

Death (any cause): Yes ☐ No☐
Description: _____
_____

Date of occurrence _ _/_ _/_ _

Hospital Admission: Yes ☐ No☐
Description: _____
_____

Was the admission as a result of a fall? Yes ☐ No☐

Injurious fall without Admission: Yes ☐ No☐
Description: _____
_____
_____

Fall During the exercise sessions:

Did a fall or medical event occur during an actual exercise session, requiring medical attention? Yes ☐ No☐

Form completed by:
_____ (Print name) Date_ _/_ _/_ _____ (Signature)

Form reviewed by
_____ (Print name) Date_ _/_ _/_ _ _____ (Signature)

For Principal Investigator

Is this event an SAE relating to patient safety in the trial?

☐ Yes – inform TSC, convene meeting to discuss trial safety

☐ No – no further action required

Signed by Chair of TSC **Date**