2 week Complications form

Participant Trial Number: | | | | **Hospital site code:** | | | | |

PLEASE ENSURE THAT THE PATIENT REMAINS BLINDED TO THEIR TREATMENT ALLOCATION AT ALL TIMES

Please ask the participant the following questions:

1. Have you experienced any of the following at the injection site since your trial treatment appointment?

please select all that apply:

Yes	No	
☐	☐	bruising and discomfort at the injection site
☐	☐	fainting episode associated with tendon injection treatment
☐	☐	an infection diagnosed by a doctor
☐	☐	mild discomfort and bleeding
☐	☐	swelling
☐	☐	skin discolouration
☐	☐	allergic reaction
☐	☐	Other *please specify* ……

2. If any of those listed above have been ticked as **Yes**, have you received any treatment?

☐ **Yes** ☐ **No**

2.a. If **Yes**, what treatment ……

2 b. Had this/ Have these (that you ticked **Yes** to in Q1) now resolved?

☐ **Yes** ☐ **No**

2.c. If **No**, please detail ……

3. Have any contact details changed since the last appointment? ☐ **Yes** ☐ **No**

If **Yes**, please complete the **Change of Contact details form at the back of this booklet**.

FOR OFFICE USE ONLY

Does the event detailed above meet the requirements of an SAE? ☐ **Yes** ☐ **No**

If yes, please notify the Trial Coordinator to initiate the completion of an SAE form.

FORM COMPLETED BY (PRINT NAME): _____

SIGNATURE: _____ **DATE SIGNED:** d d – m m m – y y y y