



# 2 week Complications form

Participant Trial Number:

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Hospital site code:

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**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 complications associated with receiving the trial injection?

*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** with the participant.

## 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
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