



2 week Complications form - bilateral

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 about their trial tendon:

1. Have you experienced any of the following complications associated with receiving the trial injection?

please select all that apply:

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
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bruising and discomfort at the injection site

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

fainting episode associated with tendon injection treatment

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

an infection diagnosed by a doctor

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

mild discomfort and bleeding

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

swelling

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

skin discolouration

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

allergic reaction

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

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.

4. Please rate your pain on a scale of 0-100.....
0 being "No pain" and 100 being "Worst pain imaginable"

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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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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 about their non-trial tendon:

1. Have you experienced any of the following complications associated with receiving the trial injection?

please select all that apply:

Yes No

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

bruising and discomfort at the injection site

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

fainting episode associated with tendon injection treatment

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

an infection diagnosed by a doctor

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

mild discomfort and bleeding

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

swelling

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

skin discolouration

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

allergic reaction

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

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.

4. Please rate your pain on a scale of 0-100.....

0 being "No pain" and 100 being "Worst pain imaginable"

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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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