2 week Complications form - bilateral

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

Please ask the participant the following questions about their trial tendon:

1. Have you/ Are you currently experienced any of the following at the injection site?

For office use	Yes	No	
1	☐	☐	bruising at the injection site
2	☐	☐	fainting episode associated with tendon injection treatment
3	☐	☐	an infection diagnosed by a doctor
4	☐	☐	mild discomfort associated with tendon injection treatment
5	☐	☐	bleeding associated with tendon injection treatment
6	☐	☐	swelling
7	☐	☐	skin discolouration
8	☐	☐	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 ……..

……

……

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

☐ **Yes** ☐ **No**

3.a. If **No**, please detail ……..

……

……

4. Are there any other details: ……...

……

……

5. Please rate your pain on a scale of 0-100……. *number*

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

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

If **Yes**, please complete the **Change of Contact details form**

FOR OFFICE USE ONLY

Do any of the events detailed above meet the definition of an SAE? ☐ **Yes** ☐ **No**

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

Date Chief Investigator made aware of AEs/ SAEs : d d – m m m – y y y y

FORM COMPLETED BY (PRINT NAME): _____

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

2 week Complications form - bilateral

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

Please ask the participant the following questions about their non-trial tendon:

1. Have you/ Are you currently experienced any of the following at the injection site?

For office use	Yes	No	
1	☐	☐	bruising at the injection site
2	☐	☐	fainting episode associated with tendon injection treatment
3	☐	☐	an infection diagnosed by a doctor
4	☐	☐	mild discomfort associated with tendon injection treatment
5	☐	☐	bleeding associated with tendon injection treatment
6	☐	☐	swelling
7	☐	☐	skin discolouration
8	☐	☐	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 ……..

……

……

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

☐ **Yes** ☐ **No**

3.a. If **No**, please detail ……..

……

……

4. Are there any other details: ……...

……

……

5. Please rate your pain on a scale of 0-100……. *number*

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

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

If **Yes**, please complete the **Change of Contact details form**

FOR OFFICE USE ONLY

Do any of the events detailed above meet the definition of an SAE? ☐ **Yes** ☐ **No**

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

Date Chief Investigator made aware of AEs/ SAEs : d d – m m m – y y y y

FORM COMPLETED BY (PRINT NAME): _____

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