# 2 week Complications form - single

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

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

1. Have you/Are you currently experiencing 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