Form number: 8

Discharge Form

sepsis adapt
Biomarker-guided antibiotic duration for sepsis

Participant Trial Number: ☐☐☐☐ **Participant Initials:** ☐☐

Randomising Site:

A. Discharge:

1) Was participant discharged alive from treating hospital? No ☐ Yes ☐ *If no, please skip the remainder of this form and complete death form.*

If yes, date and time of discharge from hospital: d d – m o n – y y y y
h h : m m

2) Please mark with a cross where the participant was discharged to:

Home ☐ Nursing/ Residential home ☐
Another hospital - specify:
Other - specify:

3) Was the participant discharged on a course of systemic (IV/oral/rectal) antibiotics? No ☐ Yes ☐

If yes, complete Antibiotic —Follow-up Form

i) If yes, was this for the initial suspected sepsis episode? No ☐ Yes ☐

Form completed by (print name): _____ *(Please note: your name must be on the trial delegation log)*

Signature: _____ **Date signed:** d d – m o n – y y y y

Completion Guidelines for CRF 8: Discharge Form

This form should be completed when a patient is discharged from the hospital.

Participant Initials:	Write the initials of the participant's first/given name and surname/family name only. For double barrelled surnames/ family names use the initial from the first part of the surname/family name.
Dates:	Please use the following formats for dates: 06-Jun-1956.
Times:	Please record all times in the 24-hour format.

Discharge Guidance:

- If patient discharged to another hospital, please specify the name of the hospital not the trust name.