



# CLINICAL REPORT FORM

FOLLOW-UP 1 (FU1)

## ARMED SERVICES TRAUMA REHABILITATION OUTCOME STUDY

[ADVANCE STUDY]

[WWW.ADVANCESTUDYDMRC.ORG.UK](http://WWW.ADVANCESTUDYDMRC.ORG.UK)

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MODREC Protocol Number: 357/PPE/12      Date \_\_\_\_/\_\_\_\_/\_\_\_\_(dd/mm/yyyy)

# ADVANCE STUDY – CLINICAL REPORT FORM

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## Section A: INCLUSION / EXCLUSION CRITERIA

1. Study Group	[[Question not required anymore]]									
2. Participant willing and able to give informed consent	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
3. Informed Consent form signed	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
4. Version of Consent form  Please TICK each statement that has been read and initialled on the paper consent form	<p>Version: <input type="checkbox"/> . <input type="checkbox"/></p> <p>Date: <table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table></p> <p><input type="checkbox"/><sub>1</sub> <input type="checkbox"/><sub>2</sub> <input type="checkbox"/><sub>3</sub> <input type="checkbox"/><sub>4</sub> <input type="checkbox"/><sub>5</sub> <input type="checkbox"/><sub>6</sub> <input type="checkbox"/><sub>7</sub></p> <p>ADVANCE Consent form v4.4 (updated: 24-02-2022)</p>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
5. Measurements (a) Temperature >38°C  (b) Resting heart rate >90 beats/min*  (c) Respiratory rate >20 breaths/min*	<p><input type="checkbox"/><sub>1</sub> Yes <input type="checkbox"/><sub>0</sub> No <input type="text"/> <input type="text"/> . <input type="text"/> °C</p> <p><input type="checkbox"/><sub>1</sub> Yes <input type="checkbox"/><sub>0</sub> No <input type="text"/> <input type="text"/> <input type="text"/> beats/min</p> <p><input type="checkbox"/><sub>1</sub> Yes <input type="checkbox"/><sub>0</sub> No <input type="text"/> <input type="text"/> breaths/min</p>									
6. Active acute infection (Yes to 2 or more above*: exclude)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
7. Date participant excluded	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
8. Reason for exclusion	<input type="checkbox"/> <sub>1</sub> Unable or unwilling to give informed consent <input type="checkbox"/> <sub>2</sub> Active acute infection <input type="checkbox"/> <sub>3</sub> Other (specify) _____									
9. Initials of clinician taking consent	_____									
10. Visit's results phone call (Results letter is mandatory)	<input type="checkbox"/> <sub>1</sub> Opt in <input type="checkbox"/> <sub>2</sub> Opt out									

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## Section B: BIOMETRIC EXAMINATION & Q-RISK CALCULATION

14. Do you know if you have had COVID-19 (coronavirus)?	<input type="checkbox"/> <sub>1</sub> I've definitely had it, and had it confirmed by a test <input type="checkbox"/> <sub>2</sub> I think I've probably had it <input type="checkbox"/> <sub>3</sub> I don't know whether I've had it or not <input type="checkbox"/> <sub>4</sub> I think I've probably not had it <input type="checkbox"/> <sub>5</sub> I've definitely not had it																				
15. Fasted for 8 hours?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	16. Duration: _____ hours																		
17. Smoked within last 4 hours?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	If Yes delay Vicorder assessment >4 hours after last cigarette if possible																		
18. Height	<div> <input type="text"/> <input type="text"/> <input type="text"/> (cm)         </div> <div> <input type="checkbox"/><sub>1</sub> Actual    <input type="checkbox"/><sub>2</sub> Reported    <input type="checkbox"/><sub>3</sub> Estimate         </div>																				
19. Weight without prosthetic(s)	<div> <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> (kg)         </div>																				
20. Amputee (lower limbs)  Codes: PD / TF / KD/ TT / AD / PF	<div> <input type="checkbox"/><sub>1</sub> Yes  <input type="checkbox"/><sub>0</sub> No         </div> <div>           Code(s): Right side _____            Left side _____         </div>																				
21. Osseointegration	<div> <b>No</b> <input type="checkbox"/><sub>0</sub>    <b>One leg</b> <input type="checkbox"/><sub>1</sub>    <b>Both legs</b> <input type="checkbox"/><sub>2</sub> </div> <div>           If <b>One</b> or <b>Both</b>, date(s):         </div> <div> <table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> </div> <div> <table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> </div>			D	D	M	M	M	Y	Y	Y	Y	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y													
D	D	M	M	M	Y	Y	Y	Y													
22. Abdominal circumference	<div> <input type="text"/> <input type="text"/> <input type="text"/> cm         </div>																				
23. Hip circumference	<div> <input type="text"/> <input type="text"/> <input type="text"/> cm         </div>																				

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## Section B: BIOMETRIC EXAMINATION & Q-RISK CALCULATION

24. Ethnicity	<input type="checkbox"/> <sub>1</sub> White <input type="checkbox"/> <sub>3</sub> Pakistani <input type="checkbox"/> <sub>5</sub> Other Asian <input type="checkbox"/> <sub>7</sub> Black African <input type="checkbox"/> <sub>9</sub> Other ethnic group (including 'mixed') <input type="checkbox"/> <sub>10</sub> Not stated	<input type="checkbox"/> <sub>2</sub> Indian <input type="checkbox"/> <sub>4</sub> Bangladeshi <input type="checkbox"/> <sub>6</sub> Black Caribbean <input type="checkbox"/> <sub>8</sub> Chinese	
25. Smoking status	<input type="checkbox"/> <sub>1</sub> Non-smoker <input type="checkbox"/> <sub>3</sub> Light smoker (<10) <input type="checkbox"/> <sub>5</sub> Heavy smoker (20+)	<input type="checkbox"/> <sub>2</sub> Ex-smoker <input type="checkbox"/> <sub>4</sub> Moderate smoker (10-19)	
26. Diabetes status	<input type="checkbox"/> <sub>1</sub> Type 1	<input type="checkbox"/> <sub>2</sub> Type 2	<input type="checkbox"/> <sub>3</sub> None
27. Angina or heart attack in a 1st degree relative, age < 60?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
28. Chronic kidney disease (stage 3, 4 or 5)?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
29. Atrial fibrillation?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
30. On blood pressure treatment?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
31. Do you have migraines?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
32. Rheumatoid arthritis?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
33. Systemic lupus erythematosus?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
34. Severe mental illness? (schizophrenia, bipolar disorder or moderate/severe depression)	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
35. On antipsychotic medication?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
36. On regular steroid tablets?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	
37. Diagnosis of, or treatment for, erectile dysfunction?	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No	

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## Section C: SIGNIFICANT MEDICAL HISTORY

(since last ADVANCE visit)

- Make multiple copies of this page if required

### ICD10 system block codes

Chapter	Title	Chapter	Title
I	Certain infectious and parasitic diseases	XII	Diseases of the skin and subcutaneous tissue
II	Neoplasms	XIII	Diseases of the musculoskeletal system and connective tissue
III	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	XIV	Diseases of the genitourinary system
IV	Endocrine, nutritional and metabolic diseases	XV	DO NOT USE
V	Mental and behavioural disorders	XVI	DO NOT USE
VI	Diseases of the nervous system	XVII	Congenital malformations, deformations and chromosomal abnormalities
VII	Diseases of the eye and adnexa	XVIII	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
VIII	Diseases of the ear and mastoid process	XIX	Injury, poisoning and certain other consequences of external causes
IX	Diseases of the circulatory system	XX	External causes of morbidity and mortality
X	Diseases of the respiratory system	XXI	Factors influencing health status and contact with health services
XI	Diseases of the digestive system	XXII	Codes for special purposes

ICD10 system code: <http://apps.who.int/classifications/apps/icd/icd10online/>

Does the participant have a history of any background/conditions/symptoms according to the following schedule?

38. ☐<sub>1</sub> Yes ☐<sub>0</sub> No

If **Yes**, detail in the table below and reference the **ICD10 system block codes**

Block code	Condition/Symptom	Onset Date	Stop Date														
A 1 1		<table><tr><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table> OR <input type="checkbox"/> _1 Unknown	M	M	M	Y	Y	Y	Y	<table><tr><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table> OR <input type="checkbox"/> _1 Ongoing	M	M	M	Y	Y	Y	Y
M	M	M	Y	Y	Y	Y											
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## Section D: OPERATIONS/SURGICAL PROCEDURES

(since last ADVANCE visit)

- Make multiple copies of this page if required

Has the participant had any operations/surgery since his last visit to ADVANCE?

39. ☐<sub>1</sub> Yes

☐<sub>0</sub> No

If Yes, give details below

Date of procedure	Body region	Indication	Type of surgery										
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					
<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y				<input type="checkbox"/> <sub>1</sub> Ongoing <input type="checkbox"/> <sub>2</sub> Resolved
D	D	M	M	M	Y	Y	Y	Y					

Key (Body Regions):

**[H]** Head    **[UL]** Upper Limb

**[T]** Torso    **[LL]** Lower Limb

## ADVANCE STUDY – CLINICAL REPORT FORM

<b>A</b>	<b>D</b>	<b>V</b>				
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ADV number

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4 letter code

### Section E: Medications

## Anatomical Therapeutic Chemical (ATC)

### Level-1 Classification

A: Alimentary tract and metabolism

B: Blood and blood forming organs

C: Cardiovascular system

D: Dermatologicals

G: Genito urinary system and sex hormones

H: Systemic hormonal preparations, excluding sex hormones and insulins

J: Antiinfective for systemic use

L: Antineoplastic and immunomodulating agents

M: Musculo-skeletal system

N: Nervous system

P: Antiparasitic products, insecticides and repellents

R: Respiratory system

S: Sensory organs

V: Various

## ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code



# HOW TO USE THE ATC CODES

1

## GENERIC NAME OF MEDICATION

If possible, always get the generic name of the medication/active ingredients. If not possible, take the specific name and investigate later.

2

## INDICATION

The indication will impact on how the medication is coded.

3

## SEARCH THE ATC DATABASE

enter your drug name into the database. Make sure the group links to the indication of the drug. If it does not, you might need to use a different, generic code.

4

## EXAMPLES OF MOST USED CODES

TRAMADOL: N02AX02

NAPROXEN: M01AE02

COCODAMOL: N02AJ06

OMEPRazole: A02BC01

SERTRALINE: N06AB06

PARACETAMOL: N02BE01

IBUPROFEN: M01AE01

ANALGESICS: N02

*Example drugs given N02 code: AMITRIPTYLINE, DIAZEPAM, DULOXETINE, GABAPENTIN, NORTRPTYLINE, PREGABALIN*

### Tips:

- If you're not sure-wait and discuss!
- Always put as much info in the free text box as possible for quality checking.
- The indications and medications must link together with the ATC category. E.g. if a medication appears in the N06 (mental health) but the participant is using it for pain, N06 is not the appropriate category.

# ADVANCE STUDY – CLINICAL REPORT FORM

A	D	V				
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ADV number

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4 letter code

## Section E: Medications

40. Is the participant currently taking any medications? ☐<sub>1</sub> Yes ☐<sub>0</sub> No

If Yes, detail in the table below:

Drug Name	Frequency	Dose (& units)	Route	PSP/OTC	Indication	Year started				
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							

Abbreviation	OD	BD	TDS	QDS	PRN	NOC TE	MANE	INH	IM	SC	SL	TD	PR	TOP	PO	IV	PSP	OTC
Definition	Once daily	Twice Daily	3 Times Daily	4 Times daily	As required	At night time	In the morning	Inhaler	Intra- muscular	Sub- cutaneous	Sub- lingual	Trans- dermal	Rectal	Topical	Oral	Intra venous	Presc- ription	Over the Counter

# ADVANCE STUDY – CLINICAL REPORT FORM

<b>A</b>	<b>D</b>	<b>V</b>				
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ADV number

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4 letter code

## Section E: Medications (cont.)

40. Is the participant currently taking any medications? ☐<sub>1</sub> Yes ☐<sub>0</sub> No

If Yes, detail in the table below:

Drug Name	Frequency	Dose (& units)	Route	PSP/OTC	Indication	Year started				
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							
						<table border="1"> <tr> <td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> <sub>1</sub> Unknown	Y	Y	Y	Y
Y	Y	Y	Y							

Abbreviation	OD	BD	TDS	QDS	PRN	NOC TE	MANE	INH	IM	SC	SL	TD	PR	TOP	PO	IV	PSP	OTC
Definition	Once daily	Twice Daily	3 Times Daily	4 Times daily	As required	At night time	In the morning	Inhaler	Intra-muscular	Sub-cutaneous	Sub-lingual	Trans-dermal	Rectal	Topical	Oral	Intra venous	Prescription	Over the Counter

# ADVANCE STUDY – CLINICAL REPORT FORM

<b>A</b>	<b>D</b>	<b>V</b>				
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ADV number

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4 letter code

## Section F: FAMILY HISTORY (first degree relative: parent/sibling/child)

### 41. HAS ANYONE IN YOUR FAMILY SUFFERED FROM THE FOLLOWING?

	Yes	No	Not Known
Ischaemic heart disease (heart attack/angina)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>
Stroke	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>
High blood pressure	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>
Diabetes	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>
Mental health problems	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>
Arthritis	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>
Cancer	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>2</sub>

IF YES:	Who in family <i>(use multiple codes if required e.g. M, F, B)</i>	Age If age not known, <60 or >60 years old?	R	O	D
Ischaemic heart disease (heart attack/angina)			<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Stroke			<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
High blood pressure			<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Diabetes			<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Mental health problems			<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Arthritis			<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>
Cancer			<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>

### Key:

#### Family Relationships

[F] Father [M] Mother  
[B] Brother [S] Sister  
[Sn] Son [Da] Daughter

#### Status

[R] Resolved  
[O] Ongoing  
[D] Deceased

## ADVANCE STUDY – CLINICAL REPORT FORM

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ADV number

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4 letter code

### Section G: SMOKING / TOBACCO USE: Cigarettes / Pipes

42. Do you currently smoke or have you ever smoked?

Never	<input type="checkbox"/> <sub>1</sub>				
Ex-smoker	<input type="checkbox"/> <sub>2</sub>	number of cigarettes/ pipes / roll-ups per day	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>		
Smoker	<input type="checkbox"/> <sub>3</sub>	number of cigarettes/ pipes / roll-ups per day	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>		
Age started smoking:		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			years
Age stopped smoking:		<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			years

### SMOKING: electronic

43. Do you currently or have previously used e-cigarettes?	<input type="checkbox"/> <sub>1</sub>	Yes	<input type="checkbox"/> <sub>0</sub>	No		
Age started using e-cigarettes:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			years		
Are you a current e-cigarette smoker?	<input type="checkbox"/> <sub>1</sub>	Yes	<input type="checkbox"/> <sub>0</sub>	No		
Age stopped using e-cigarettes:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			years		

### NICOTINE-REPLACEMENT (NRT)

44. Do you currently or have previously used NRT?	<input type="checkbox"/> <sub>1</sub>	Yes	<input type="checkbox"/> <sub>0</sub>	No		
Age started using NRT:	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>			years		

# ADVANCE STUDY – CLINICAL REPORT FORM

<b>A</b>	<b>D</b>	<b>V</b>							
ADV number						4 letter code			

Are you a current NRT user?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No		
Age stopped using NRT:	<table border="1"> <tr> <td></td> <td></td> </tr> </table> years		



# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

## Section H:

### ASAS EXPERTS FOR INFLAMMATORY BACK PAIN

<b>45. Chronic back pain &gt;3 months (now or previously)</b>  <i>(If <b>YES</b>, continue, if <b>NO</b>, stop and continue to next section)</i>	<b>YES</b>	<b>NO</b>
Did your back pain start when you were aged 40 or under?	Yes <input type="checkbox"/> <sub>1</sub>  <i>Age at onset if ≤ 40</i>  _____ years	No <input type="checkbox"/> <sub>0</sub>
Insidious onset	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>
Improvement with exercise	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>
No improvement with rest	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>
Pain at night (with improvement on getting up)	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>
Yes to 4 out of 5 parameters?	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>

# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

## Section I: SPONDYLOARTHROPATHY FEATURES (SpA)

**46. Check if participant has a previous diagnosis of:**

	YES	NO
Inflammatory back pain	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Arthritis	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Enthesitis (heel pain)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Uveitis	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Dactylitis (sausage-like fingers)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Psoriasis	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Crohn's Disease/colitis	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Good response to NSAIDs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>
Family history of SpA	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>0</sub>

# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

## Section J: HEAD INJURIES

**Step 1: 47. “I am going to ask you about injuries to your head or neck that you may have had anytime in your life.”**

*Ask questions 1-5 below.*

*Record the cause of each reported injury and any details provided spontaneously in the chart at the bottom of this page. You do not need to ask further about loss of consciousness or other injury details during this step.*

1. In your lifetime, have you ever been hospitalized or treated in an emergency room following an injury to your head or neck? Think about any childhood injuries you remember or were told about.	2. In your lifetime, have you ever injured your head or neck in a car accident or from crashing some other moving vehicle like a bicycle, motorcycle or ATV?	3. In your lifetime, have you ever injured your head or neck in a fall or from being hit by something (for example, falling from a bike or horse, rollerblading, falling on ice, being hit by a rock)? Have you ever injured your head or neck playing sports or in the playground?	4. In your lifetime, have you ever injured your head or neck in a fight, from being hit by someone, or from being shaken violently? Have you ever been shot in the head?	5. In your lifetime, have you ever been nearby when an explosion or a blast occurred? Think about any combat- or training-related incidents.
Yes (record cause) <input type="checkbox"/> <sub>1</sub>	Yes (record cause) <input type="checkbox"/> <sub>1</sub>	Yes (record cause) <input type="checkbox"/> <sub>1</sub>	Yes (record cause) <input type="checkbox"/> <sub>1</sub>	Yes (record cause) <input type="checkbox"/> <sub>1</sub>
No <input type="checkbox"/> <sub>0</sub>	No <input type="checkbox"/> <sub>0</sub>	No <input type="checkbox"/> <sub>0</sub>	No <input type="checkbox"/> <sub>0</sub>	No <input type="checkbox"/> <sub>0</sub>

### Step 2:

*If the answer is “yes” to any of the questions in Step 1 ask the following additional questions about each reported injury and add details to the chart overleaf.*

**(Pg17)**

*If all answers were no, skip to step 3.*

# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

**Step 2: 48. “Were you knocked out or did you lose consciousness (LOC)? If yes, how long? If no, were you dazed or did you have a gap in your memory from the injury? How old were you?”**

Step 1: record cause	Cause	Step 2: Details	Loss of consciousness/Knocked out	Dazed/Mem Gap	Age (in years)
			No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>0</sub>	
			No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>0</sub>	
			No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>0</sub>	
			No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>0</sub>	
			No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>0</sub>	
			No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Yes <input type="checkbox"/> <sub>1</sub> No <input type="checkbox"/> <sub>0</sub>	

# ADVANCE STUDY – CLINICAL REPORT FORM

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ADV number

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4 letter code

## Section K: Head Injuries (step 3)

**Step 3: 49.** Ask the following questions to help identify a history that may include multiple mild TBIs and complete the chart below.

Cause of repeated injury Have you ever had a period of time in which you experienced multiple, repeated impacts to your head (e.g. history of abuse, contact sports, military duty)?	Typical effect If yes, what was the typical or usual effect—were you knocked out/LOC? If no, were you dazed or did you have a gap in your memory from the injury?	Most severe effect What was the most severe effect from one of the times you had an impact to the head?	Age How old were you when these repeated injuries began? Ended?
	No LOC <input type="checkbox"/> <sub>1</sub> Dazed/memory gap <input type="checkbox"/> <sub>2</sub> LOC <input type="checkbox"/> <sub>3</sub>	No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Age began: _____ Age ended: _____
	No LOC <input type="checkbox"/> <sub>1</sub> Dazed/memory gap <input type="checkbox"/> <sub>2</sub> LOC <input type="checkbox"/> <sub>3</sub>	No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Age began: _____ Age ended: _____
	No LOC <input type="checkbox"/> <sub>1</sub> Dazed/memory gap <input type="checkbox"/> <sub>2</sub> LOC <input type="checkbox"/> <sub>3</sub>	No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Age began: _____ Age ended: _____
	No LOC <input type="checkbox"/> <sub>1</sub> Dazed/memory gap <input type="checkbox"/> <sub>2</sub> LOC <input type="checkbox"/> <sub>3</sub>	No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Age began: _____ Age ended: _____
	No LOC <input type="checkbox"/> <sub>1</sub> Dazed/memory gap <input type="checkbox"/> <sub>2</sub> LOC <input type="checkbox"/> <sub>3</sub>	No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Age began: _____ Age ended: _____
	No LOC <input type="checkbox"/> <sub>1</sub> Dazed/memory gap <input type="checkbox"/> <sub>2</sub> LOC <input type="checkbox"/> <sub>3</sub>	No LOC <input type="checkbox"/> <sub>1</sub> <30 minutes <input type="checkbox"/> <sub>2</sub> 30 minutes-24 hours <input type="checkbox"/> <sub>3</sub> >24 hours <input type="checkbox"/> <sub>4</sub>	Age began: _____ Age ended: _____

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4 letter code

## Section L: HEAD INJURIES

If the participant answered yes to any question in step 1 of the Ohio state questionnaire, please ask them to complete this questionnaire. If not, please skip this section.

*“After a head injury or accident some people experience symptoms that can cause worry or nuisance. We would like to know if you now suffer any of the symptoms given below. Because many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom listed below please circle the number that most closely represents your answer”.*

### 50. Compared with BEFORE the injury, do you NOW (i.e. over the last 24 hours) suffer from:

	Not experienced	No more of a problem	Mild problem	Moderate problem	Severe problem
Headaches	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Feelings of dizziness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Nausea or vomiting	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Noise sensitivity (easily upset by loud noises)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Sleep disturbance	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Fatigue, tiring more easily	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Being irritable, easily angered	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Feeling depressed or tearful	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Feeling frustrated or impatient	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Poor concentration	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Taking longer to think	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Blurred vision	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Light sensitivity (easily upset by bright light)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Double vision	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Restlessness	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

### Are you experiencing any other difficulties? Please specify and rate

	Not experienced	No more of a problem	Mild problem	Moderate problem	Severe problem
1. _____ _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. _____ _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. _____ _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. _____ _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. _____ _____	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

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## Section M: VICORDER

51. Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date Performed	D	D	M	M	M	Y	Y	Y	Y
52. Clinician's Initials										
Which laptop used	<input type="checkbox"/> <sub>1</sub> Laptop 1 <input type="checkbox"/> <sub>2</sub> Laptop 2 <input type="checkbox"/> <sub>3</sub> Laptop 3									
53. Resting heart rate (bpm)	<input type="text"/> <input type="text"/> <input type="text"/> bpm									
54. Ipsilateral/Contralateral?	<input type="checkbox"/> <sub>1</sub> <b>Ipsilateral</b> (standard is left side; if not possible measure right side)					<input type="checkbox"/> <sub>2</sub> <b>Contralateral</b> (standard is left leg/right arm; if not possible measure right leg/left arm)				
	<b>Blood Pressure</b> Systolic / Diastolic					<b>Augmentation Index (%)</b>				
55. PWA measurement 1	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>					<input type="text"/> <input type="text"/>				
56. PWA measurement 2	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>					<input type="text"/> <input type="text"/>				
57. PWA measurement 3	<input type="text"/> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>					<input type="text"/> <input type="text"/>				
58. PWV measurement 1	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>									
59. PWV measurement 2	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>									
60. PWV measurement 3	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/>									
61. Clinician's comments:										

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## SECTION N: HEART RATE VARIABILITY

62(a). Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date								
	Performed	D	D	M	M	M	Y	Y	Y

62(b). Clinician's Initials	_____
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62 (c). Which laptop used	<input type="checkbox"/> <sub>1</sub> Laptop 1
	<input type="checkbox"/> <sub>2</sub> Laptop 2
	<input type="checkbox"/> <sub>3</sub> Laptop 3

62. Room temperature:   .  °C

63. Strenuous exercise in previous 24 hours: ☐<sub>1</sub> Yes ☐<sub>0</sub> No

64. If Yes, was this unaccustomed (abnormal activity for the participant)?

☐<sub>1</sub> Yes ☐<sub>0</sub> No

65. Description of activity:

66. Time Recordings	Start time on timer	Start time on Clock (Actual time)
Spontaneous breathing		
Paced breathing		

67. Comments

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## Section O: SPIROMETRY

70. Performed? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No	Date Performed :	D	D	M	M	Y	Y	Y	Y
---	------------------	---	---	---	---	---	---	---	---

If no, please comment why not	_____	Were contraindications checked? <input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
-------------------------------	-------	---

71. Clinician's Initials

\_\_\_\_\_

Which laptop used

- ☐<sub>1</sub> Laptop 1  
☐<sub>2</sub> Laptop 2  
☐<sub>3</sub> Laptop 3

72. Position when taken: ☐<sub>1</sub> Standing  
(Tick only **one** box) ☐<sub>2</sub> Sitting

73. How many tests attempted?

--	--

74 (a). Measurement (litres)

FEV<sub>1</sub>     
FVC     
Ratio

74 (b). Percentage predicted score

FEV<sub>1</sub>    %  
FVC    %

75. Participant encountered problems during the Spirometry tests

- ☐<sub>0</sub> No problems encountered  
☐<sub>1</sub> Struggled with technique  
☐<sub>2</sub> Cold/flu-like symptoms  
☐<sub>3</sub> Coughing  
☐<sub>4</sub> In pain  
☐<sub>5</sub> Other problems \_\_\_\_\_

76. Clinician's

Comments:


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## Section P: AUDIOMETRY / OTOSCOPY EXAMINATION

77. Clinician's Initials

\_\_\_\_\_

Previous test showed asymmetry?

☐<sub>1</sub> Yes

☐<sub>2</sub> No

☐<sub>3</sub> N/A

78. Are you still serving in the military?

(If Yes, hearing test is not required – please populate results from last hearing test)

(if reservist, see SOP for clarification)

☐<sub>1</sub> Yes

☐<sub>0</sub> No

79. Date of Examination:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

80. Any contraindication to proceeding with Audiogram?

☐<sub>1</sub> Yes

☐<sub>0</sub> No

☐<sub>2</sub> Not done

If YES or NOT done, give details:

\_\_\_\_\_  
 \_\_\_\_\_

Any other findings of note, give details

\_\_\_\_\_  
 \_\_\_\_\_

81. Hearing booth used for test?

☐<sub>1</sub> Yes

☐<sub>0</sub> No

If NO please comment:

\_\_\_\_\_  
 \_\_\_\_\_

82. Date of Hearing Test Performed

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

83. Measurements

Frequency	Left ear (+/-)	Right ear (+/-)
500 Hz	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
1 kHz	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
2 kHz	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
3 kHz	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
4 kHz	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
6 kHz	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

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<b>8 Hz</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Has GP already been informed about hearing asymmetry in this participant?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No <input type="checkbox"/> <sub>2</sub> N/A	For information only, based on PREVIOUS visits

## Section Q: AUDIOMETRY

84. Have you noticed any change in your hearing?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
85. Do you have trouble hearing or understanding normal conversation?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
86. Do other people complain about your hearing and/or the loudness at which you listen to radio or TV?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
87. Do you experience frequent earaches, ear infections, excess earwax or discharge from your ear?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
88. Do you experience ringing or buzzing in the ear?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
89. Have you ever been diagnosed with deaf ear/total loss of hearing?	<input type="checkbox"/> <sub>1</sub> Left <input type="checkbox"/> <sub>2</sub> Right <input type="checkbox"/> <sub>3</sub> Both <input type="checkbox"/> <sub>0</sub> No									
90. Have you ever had a perforated or burst ear drum?	<input type="checkbox"/> <sub>1</sub> Left <input type="checkbox"/> <sub>2</sub> Right <input type="checkbox"/> <sub>3</sub> Both <input type="checkbox"/> <sub>0</sub> No									
When did this happen and why?	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
(Enter details here)										
91. Have you consulted an ENT specialist in the last year?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
If yes, when?	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
92. Have you had ear surgery recommended or performed?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
93. Do you use a hearing aid or have you been fitted for one? (Remove for test)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
94. Have you had a cold, flu or sinus problem(s) in the last 7 days?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
95. Does your current job involve regular exposure to loud noise (e.g. firearms, artillery fire, power tools, aircraft, motor boats, heavy machinery?)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
If yes, please give details:										
96. Do you regularly use an iPod, MP3 player or equivalent device?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									

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97. Do you have any noisy hobbies?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
98. Have you had past exposure to explosion or blast?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
99. In the past 48 hours have you been exposed to loud noise?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
<b>The audio questions <u>below (Q17-Q22)</u> were added on 10/02/2023</b>	<b>If the answers are 'yes' to any of the questions <u>below</u>, then "Urgent referral to GP/MO required. See section 9 of associated SoP"</b>
Q17. Has your hearing loss developed suddenly (over a period of 3 days or less) within the last 30 days?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
Q18. Has your hearing loss developed suddenly more than 30 days ago OR has it worsened rapidly (over a period of 40 to 90 days)?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
Q19. Have you experienced new intolerances of everyday sounds causing distress day to day (hyperacusis)?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
Q20. Have you experienced Increasing pulsatile distressing tinnitus?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
Q21. Have you experienced new Vertigo (a sensation of spinning around) ?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No
Q22. Have you developed a new facial weakness or numbness associated with hearing loss on the same side	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No

### Section R: IMAGING: X-RAY

100. Was the XRAY Performed?	<input type="checkbox"/> <sub>1</sub> Yes <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">D</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">M</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> <td style="width: 20px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
	<input type="checkbox"/> <sub>0</sub> No									
<b>If No</b>	<input type="checkbox"/> <sub>1</sub> X-RAY equipment out of service <input type="checkbox"/> <sub>2</sub> Participant refused									
101. Pelvis anterior / posterior (rotation 15°)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
<b>If No</b>	<input type="checkbox"/> <sub>1</sub> Participant has Bilateral Hip replacements <input type="checkbox"/> <sub>2</sub> Participant refused									
102 (a) Was LEFT KNEE XRAY performed? Knee posterior / anterior view (semi-flexed 7-10°)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
<b>If No</b>	<input type="checkbox"/> <sub>1</sub> Participant has above knee amputation <input type="checkbox"/> <sub>2</sub> Participant has full knee replacement <input type="checkbox"/> <sub>3</sub> Participant non weightbearing									
102 (b) Was RIGHT KNEE XRAY performed? Knee posterior / anterior view (semi-flexed 7-10°)	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
<b>If No</b>	<input type="checkbox"/> <sub>1</sub> Participant has above knee amputation <input type="checkbox"/> <sub>2</sub> Participant has full knee replacement <input type="checkbox"/> <sub>3</sub> Participant non weightbearing									
103. Anterior / lateral (flexion 30°)	<input type="checkbox"/> <sub>1</sub> Left <input type="checkbox"/> <sub>2</sub> Right <input type="checkbox"/> <sub>3</sub> N/A									
104. Inferior / superior / skyline	<input type="checkbox"/> <sub>1</sub> Left <input type="checkbox"/> <sub>2</sub> Right <input type="checkbox"/> <sub>3</sub> N/A									

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<b>105. X-ray or MRI sacroilitis</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
<b>106. Comments:</b>	<div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 2px;"></div> <div style="border-bottom: 1px solid black; height: 1.2em; margin-bottom: 2px;"></div>									
<b>DEXA (g/cm<sup>3</sup>) Whole Body Composition</b>										
<b>107. Date:</b>	<table style="width: 100%; border-collapse: collapse; font-family: monospace; font-size: small;"> <tr> <td style="border: 1px solid black; width: 25px; text-align: center;">D</td> <td style="border: 1px solid black; width: 25px; text-align: center;">D</td> <td style="border: 1px solid black; width: 25px; text-align: center;">M</td> <td style="border: 1px solid black; width: 25px; text-align: center;">M</td> <td style="border: 1px solid black; width: 25px; text-align: center;">M</td> <td style="border: 1px solid black; width: 25px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 25px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 25px; text-align: center;">Y</td> <td style="border: 1px solid black; width: 25px; text-align: center;">Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
<b>108. Clinician's Initials</b>	<div style="border-bottom: 1px solid black; width: 100%;"></div>									
<b>108b. Total body fat:</b> _____ (%)	<b>108c. Estimated Total VAT:</b> _____ (g/cm <sup>2</sup> )									
<b>Region</b>	<b>g/cm<sup>2</sup></b>	<b>T-score</b>								
<b>109. Total lumbar spine</b>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>								
<b>110. Total [L] hip</b>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>								
<b>111. Total [R] hip</b>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>								
<b>112. Neck of Femur [L]</b>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>								
<b>113. Neck of Femur [R]</b>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="margin: 0 5px;">.</div> <div style="border: 1px solid black; width: 25px; height: 25px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 25px; height: 25px;"></div> </div>								

### Section S: SIX MINUTE WALK TEST

**114. Clinician's Initials**

**115. Self-report BORG CR10 Scale score PRE-TEST**

- |  |  |
|--|--|
| <input type="checkbox"/> <sub>1</sub> No exertion at all<br><input type="checkbox"/> <sub>2</sub> Very, very slight (just noticeable)<br><input type="checkbox"/> <sub>3</sub> Very slight<br><input type="checkbox"/> <sub>4</sub> Slight<br><input type="checkbox"/> <sub>5</sub> Moderate | <input type="checkbox"/> <sub>6</sub> Somewhat severe<br><input type="checkbox"/> <sub>7</sub> Severe<br><input type="checkbox"/> <sub>8</sub> Very severe<br><input type="checkbox"/> <sub>9</sub> Very, very severe (almost maximal)<br><input type="checkbox"/> <sub>10</sub> Maximal |
|--|--|

## ADVANCE STUDY – CLINICAL REPORT FORM

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### 116. Self-report BORG CR10 Scale score POST-TEST

- |   |  |
|---|--|
| <input type="checkbox"/> <sub>1</sub> No exertion at all                  | <input type="checkbox"/> <sub>6</sub> Somewhat severe                    |
| <input type="checkbox"/> <sub>2</sub> Very, very slight (just noticeable) | <input type="checkbox"/> <sub>7</sub> Severe                             |
| <input type="checkbox"/> <sub>3</sub> Very slight                         | <input type="checkbox"/> <sub>8</sub> Very severe                        |
| <input type="checkbox"/> <sub>4</sub> Slight                              | <input type="checkbox"/> <sub>9</sub> Very, very severe (almost maximal) |
| <input type="checkbox"/> <sub>5</sub> Moderate                            | <input type="checkbox"/> <sub>10</sub> Maximal                           |

### 117. Maximal heart rate (BPM) at completion of 6MWT

\_\_\_\_\_ bpm

### 118. Was the 6 Minute Walk test completed?

- ☐<sub>1</sub> Yes      ☐<sub>0</sub> No

Date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

### Distance Walked (m):

\_\_\_\_\_

### Time to end of test (mins):

\_\_\_\_\_

If no, please give reason:

\_\_\_\_\_  
\_\_\_\_\_

### 119. Mobility aid used?

- ☐<sub>1</sub> Yes      ☐<sub>0</sub> No

Type of aid:

\_\_\_\_\_  
\_\_\_\_\_

## Section T: AMPUTEE MOBILITY PREDICTOR QUESTIONNAIRE

### Initial instructions:

- The participant is seated on a hard chair with arms
- The following manoeuvres are tested with or without the use of a prosthesis
- Advise the person of each task or group of tasks prior to performance
- Avoid unnecessary chatter throughout the test
- Safety first, no task should be performed if either the participant is uncertain of a safe outcome

### 120-a. AMP-Q required to be filled in?

- ☐<sub>1</sub> Yes      ☐<sub>0</sub> No

### 120. Date performed:

D	D	M	M	M	Y	Y	Y	Y
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### 121. The test is:

With prosthesis ☐

Without prosthesis ☐

# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

## Section T: AMPUTEE MOBILITY PREDICTOR QUESTIONNAIRE

<b>122. The right limb is:</b>		<b>123. The left limb is:</b>	
PF	<input type="checkbox"/>	PF	<input type="checkbox"/>
AD	<input type="checkbox"/>	AD	<input type="checkbox"/>
TT	<input type="checkbox"/>	TT	<input type="checkbox"/>
KD	<input type="checkbox"/>	KD	<input type="checkbox"/>
TF	<input type="checkbox"/>	TF	<input type="checkbox"/>
HD	<input type="checkbox"/>	HD	<input type="checkbox"/>
Intact	<input type="checkbox"/>	Intact	<input type="checkbox"/>
<b>124. Sitting balance: sit forward in chair with arms folded across chest for 60 seconds</b>			
Can't sit upright independently for 60 seconds		<input type="checkbox"/> _0	
Can sit upright independently for 60 seconds		<input type="checkbox"/> _1	
<b>126. Sitting reach: reach forward and grasp rule (hold for 12" beyond extended arms midline to sternum)</b>			
Doesn't attempt		<input type="checkbox"/> _0	
Can't grasp / needs arm support		<input type="checkbox"/> _1	
Successfully grasps item		<input type="checkbox"/> _2	
<b>127. Chair to chair transfer: 2 chairs at 90° (patient may choose direction and use ULs)</b>			
Can't do / requires physical aid		<input type="checkbox"/> _0	
Independent but appears unsteady		<input type="checkbox"/> _1	
Independent, appears steady & safe		<input type="checkbox"/> _2	
<b>128. Arises from chair: ask patient to fold arms across chest and stand. If unable, use arms or assistive device</b>			
Unable without physical aid		<input type="checkbox"/> _0	
Unable with ULs/assistive device		<input type="checkbox"/> _1	
Able without using ULs		<input type="checkbox"/> _2	
Bilaterals adjusted scoring:		Score 1 = requires physical assistance Score 2 = May use chair arms or assistive device	
<b>129. Attempts to rise from chair (stopwatch ready): if attempt in previous question was without arms then ignore and allow another attempt without penalty</b>			
Unable without physical aid		<input type="checkbox"/> _0	
Able requires > 1 attempt		<input type="checkbox"/> _1	

# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

## Section T: AMPUTEE MOBILITY PREDICTOR QUESTIONNAIRE

Able in 1 attempt

☐ <sub>2</sub>

Bilaterals adjusted scoring: May use chair arms or assistive device

### 130. Immediate standing balance (first 5s): begin timing immediately

Unsteady (staggers/sways/moves foot)

☐ <sub>0</sub>

Steady with w/aid or support

☐ <sub>1</sub>

Steady without w/aid or support

☐ <sub>2</sub>

Bilaterals adjusted scoring: May move feet to adjust BO/socket fit

### 131. Standing balance (30s stopwatch ready): for the following two questions first attempt is without assistive device. If support required, allow after first attempt

Unsteady

☐ <sub>0</sub>

Steady with w/aid or support

☐ <sub>1</sub>

Steady without w/aid or support

☐ <sub>2</sub>

### 132. Single limb standing balance (stopwatch ready): time duration of single limb stand on both sound and prosthetic limb up to 30s. Grade quality not time.

Please identify which limb (L or R) is the prosthetic limb and which is the sound limb

	Left	Right
	<b>Sound limb</b> <input type="checkbox"/> <b>Prosthetic Limb</b> <input type="checkbox"/>	<b>Sound limb</b> <input type="checkbox"/> <b>Prosthetic Limb</b> <input type="checkbox"/>
Unsteady	<input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>0</sub>
Steady with w/aid or support for 30 secs	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>1</sub>
Steady without support for 30 secs	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>2</sub>

### 133. Standing reach: reach forward and grasp ruler (hold ruler 12" beyond extended arms midline to sternum)

Doesn't attempt

☐ <sub>0</sub>

Can't grasp / requires support

☐ <sub>1</sub>

Successfully grasps item, no support

☐ <sub>2</sub>

### 134. Nudge test (subject at maximum position 7): feet as close together as possible, examiner pushes firmly on subject's sternum with palm of hand x 3 (toes should rise)

Begins to fall

☐ <sub>0</sub>

Staggers / catches self / uses support

☐ <sub>1</sub>

Steady

☐ <sub>2</sub>



# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

## Section T: AMPUTEE MOBILITY PREDICTOR QUESTIONNAIRE

**135. Eyes closed (at maximum position 7): if support is required grade as unsteady**

Unsteady / uses support	<input type="checkbox"/> 0
Steady without support	<input type="checkbox"/> 1

**136. Picking up objects from the floor (pick up a pencil from the floor placed midline 12" in front of foot)**

Unable to pick up and return to stand	<input type="checkbox"/> 0
Performs with support	<input type="checkbox"/> 1
Performs without support	<input type="checkbox"/> 2

**137. Sitting down: ask patient to fold arms across chest and sit. If unable, use arm or assistive device**

Unsafe (falls into chair/misjudges)	<input type="checkbox"/> 0
Uses arms / support / not smooth motion	<input type="checkbox"/> 1
Safe, smooth motion	<input type="checkbox"/> 2

Bilaterals adjusted scoring:  
 Score 0 = Not applicable  
 Score 1 = Unsafe (falls into chair/misjudges)  
 Score 2 = May use arms for assistance

**138. Initiation of gait (immediately after told to "go")**

Any hesitancy / multiple attempts to start	<input type="checkbox"/> 0
No hesitancy	<input type="checkbox"/> 1

**Step length and height: walk a measured distance of 12' x 2.4 scores are required or 2 scores for each leg. "Marked deviation" is defined as extreme substitute movements to permit clearing the floor.**

**139. Please identify which limb (L or R) is the prosthetic limb and which is the sound limb**

	Left	Right
Sound limb	<input type="checkbox"/>	<input type="checkbox"/>
Prosthetic Limb	<input type="checkbox"/>	<input type="checkbox"/>

**140. Swing foot score:**

Advances < 12"	<input type="checkbox"/> 0	<input type="checkbox"/> 0
Advances > 12"	<input type="checkbox"/> 1	<input type="checkbox"/> 1

**141. Foot clearance:**

# ADVANCE STUDY – CLINICAL REPORT FORM

<b>A</b>	<b>D</b>	<b>V</b>				
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4 letter code

## Section T: AMPUTEE MOBILITY PREDICTOR QUESTIONNAIRE

Deviates to clear	<input type="checkbox"/> _0	<input type="checkbox"/> _0
Clear no deviation	<input type="checkbox"/> _1	<input type="checkbox"/> _1

### 142. Step continuity:

Stopping / discontinuity between steps	<input type="checkbox"/> _0
Steps appear continuous	<input type="checkbox"/> _1

### 143. Turning: 180° when returning to chair

Unable to turn / requires intervention	<input type="checkbox"/> _0
> 3 steps without intervention	<input type="checkbox"/> _1
< 3 steps with / without support	<input type="checkbox"/> _2

### 144. Variable cadence: walk a 12" distance as fast as is safely possible x 4.

(Speeds may vary from slow to fast, varying cadence)

Unable to vary cadence with control	<input type="checkbox"/> _0
Asymmetrical controlled increase	<input type="checkbox"/> _1
Symmetrical controlled increase	<input type="checkbox"/> _2

### 145. Stepping over obstacle: place a moveable box of 4" in height in the walking path

Can't step over box	<input type="checkbox"/> _0
Catches foot / interrupts stride	<input type="checkbox"/> _1
Steps over without interrupting stride	<input type="checkbox"/> _2

### 146. Stairs (greater than or equal to 2 steps): try to go up and down stairs without holding onto railing. Don't hesitate to permit patient to hold rail. **Safety first - If examiner feels there is any risk omit and score as 0**

	Ascent	Descent
Unsteady / can't do	<input type="checkbox"/> _0	<input type="checkbox"/> _0
1 step at a time, holds rail / aid	<input type="checkbox"/> _1	<input type="checkbox"/> _1
Step over step, no support	<input type="checkbox"/> _2	<input type="checkbox"/> _2

Bilaterals adjusted scoring:

Score 1 = May require physical assistance  
Score 2 = May hold onto railing / aid

### 147. Assistive device selection: add points for use of an assistive device if used for > 2 items. If testing without prosthesis use of assistive device is mandatory

# ADVANCE STUDY – CLINICAL REPORT FORM

<b>A</b>	<b>D</b>	<b>V</b>				
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ADV number

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4 letter code

## Section T: AMPUTEE MOBILITY PREDICTOR QUESTIONNAIRE

Bedbound	0	
Wheelchair	1	
Walker	2	
Crutches	3	
Walking stick(s)	4	
No aids	5	
<b>Total Score:</b>	<b>_____ / 47</b>	

# ADVANCE STUDY – CLINICAL REPORT FORM

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4 letter code

## ADVANCE - Traumatic Brain Injury (TBI)

### TBI Informed Consent

401. Participant willing and able to give informed consent.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

402. Informed consent form signed (date).

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

403. Version of TBI Consent form

(Current:  
TBI\_Participant\_Consent\_Form\_ADVANCE\_cohort\_V1.1\_20220318)

Please TICK each statement that has been read and initialled on the paper consent form.

Version: ☐ . ☐

☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub> ☐<sub>6</sub> ☐<sub>7</sub> ☐<sub>8</sub> ☐<sub>9</sub>

### Questions prior to assessments

406. Test Date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

Test age? [Calculated field]

(Note: test date (406.) vs DOB)

\_\_\_\_ Years, \_\_ Months, \_\_ Days.

407. Was your first language English?

☐<sub>1</sub> Yes ☐<sub>0</sub> No

If NO, select first language.

☐<sub>1</sub> Afrikaans ☐<sub>2</sub> Arabic ☐<sub>3</sub> French ☐<sub>4</sub> Fijian ☐<sub>5</sub> Nepali ☐<sub>6</sub> Welsh

☐<sub>7</sub> Other (please specify) \_\_\_\_\_

408. Are you colour blind?

☐<sub>1</sub> Yes ☐<sub>0</sub> No

409. Did you experience reading, writing or spelling difficulties in school?

☐<sub>1</sub> Yes ☐<sub>0</sub> No

410. If yes to 409. then: Please Specify

(Note: more than one may be selected).

- ☐<sub>1</sub> Diagnosed dyslexia  
☐<sub>2</sub> Diagnosed dyspraxia (motor, verbal, oral)  
☐<sub>3</sub> Diagnosed dyscalculia  
☐<sub>4</sub> Diagnosed dysgraphia  
☐<sub>5</sub> Undiagnosed dyslexia  
☐<sub>6</sub> Attentional difficulties  
☐<sub>7</sub> Other (Please specify) \_\_\_\_\_

411. Do you have visual difficulties?

☐<sub>1</sub> Yes ☐<sub>0</sub> No

412. Was the participant wearing reading aids during the neuropsychological assessments?

☐<sub>1</sub> Yes ☐<sub>0</sub> No

### Test of Premorbid Functioning (TOPF)

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4 letter code

## ADVANCE - Traumatic Brain Injury (TBI)

413. Years of full-time education?	__ __ Years
414. Years of part time education?	__ __ Years
Total number of years in education. [Calculated field 13. + 14.]	__ __ Years
415. Was the TOPF Completed?  If <b>YES</b> , enter score, if <b>NO</b> , select from options and go to <b>417. Trail Making Test.</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No  <input type="checkbox"/> <sub>1</sub> Ran out of time. <input type="checkbox"/> <sub>2</sub> Participant declined to take part <input type="checkbox"/> <sub>3</sub> Eyesight difficulties <input type="checkbox"/> <sub>4</sub> Reading difficulties
416. TOPF Total Raw Score (Max = 70)	--
<b>Trail Making Test</b>	
417. Was Trail Making Test Part A completed?  If <b>YES</b> , enter score, if <b>NO</b> , select from options and go to <b>419.</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No  <input type="checkbox"/> <sub>1</sub> Ran out of time. <input type="checkbox"/> <sub>2</sub> Participant declined to take part <input type="checkbox"/> <sub>3</sub> Eyesight difficulties <input type="checkbox"/> <sub>4</sub> Reading difficulties
418. [TMT.1] Part A – Total time to complete task (seconds)	-- -- . __ seconds
419. Was Trail Making Test Part B completed?  If <b>YES</b> , enter score, if <b>NO</b> , select from options and go to <b>421. D-KEF Colour- Word Interference Test.</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No  <input type="checkbox"/> <sub>1</sub> Ran out of time. <input type="checkbox"/> <sub>2</sub> Participant declined to take part <input type="checkbox"/> <sub>3</sub> Eyesight difficulties <input type="checkbox"/> <sub>4</sub> Reading difficulties
420. [TMT.2] Part B – Total time to complete task (seconds)	-- -- . __ seconds
Trail making test B minus A (formula= TMT.2-TMT.1) [Calculated field]	-- -- . __ seconds
Trail making test B to A ratio (formula= TMT.2/TMT.1) [Calculated field]	-- -- . __ seconds

## D-KEFS Colour-Word Interference Test

# ADVANCE STUDY – CLINICAL REPORT FORM

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## ADVANCE - Traumatic Brain Injury (TBI)

<p><b>421. Was the D-KEFS Colour-Word Interference Test, Condition 1: Colour Naming completed?</b></p> <p>If NO, select from options.</p>	<p><input type="checkbox"/><sub>1</sub> Yes   <input type="checkbox"/><sub>0</sub> No</p> <p><input type="checkbox"/><sub>1</sub> Participant has marked difficulty or has made 4 uncorrected errors on the two practice lines.</p> <p><input type="checkbox"/><sub>2</sub> Ran out of time.</p> <p><input type="checkbox"/><sub>3</sub> Participant declined to continue</p> <p><input type="checkbox"/><sub>4</sub> Eyesight difficulties</p> <p><input type="checkbox"/><sub>5</sub> Reading difficulties</p>
<p><b>422. Condition 1: Colour Naming</b></p> <p>NOTE: condition for variable being shown, should be shown if 421. is Yes.</p> <p>a. Total Uncorrected Errors (Max=50)</p> <p>b. Total Self-Corrected Errors (Max=50)</p> <p>c. [CWIT.1c] Total Time to Complete</p> <p>(Note: if participant ran out of time/&gt;90s, then enter 90s.)</p>	<p>__ __ uncorrected errors</p> <p>__ __ self-corrected errors</p> <p>__ . __ seconds (Max=90seconds)</p>
<p><b>423. Was the D-KEFS Colour-Word Interference Test, Condition 2: Word Reading completed?</b></p> <p>If NO, select from options.</p>	<p><input type="checkbox"/><sub>1</sub> Yes   <input type="checkbox"/><sub>0</sub> No</p> <p><input type="checkbox"/><sub>1</sub> Participant has marked difficulty or has made 4 uncorrected errors on the two practice lines.</p> <p><input type="checkbox"/><sub>2</sub> Ran out of time.</p> <p><input type="checkbox"/><sub>3</sub> Participant declined to continue</p> <p><input type="checkbox"/><sub>4</sub> Eyesight difficulties</p> <p><input type="checkbox"/><sub>5</sub> Reading difficulties</p>
<p><b>424. Condition 2: Word Reading</b></p> <p>NOTE: condition for variable being shown, should be shown if 423. is Yes.</p> <p>a. Total Uncorrected Errors (Max=50)</p> <p>b. Total Self-Corrected Errors (Max=50)</p> <p>c. [CWIT.2c] Total Time to Complete</p> <p>(Note: if participant ran out of time/&gt;90s, then enter 90s.)</p>	<p>__ __ uncorrected errors</p> <p>__ __ self-corrected errors</p> <p>__ . __ seconds (Max=90seconds)</p>
<p><b>425. Was the D-KEFS Colour-Word Interference Test, Condition 3: Inhibition completed?</b></p> <p>If NO, select from options.</p>	<p><input type="checkbox"/><sub>1</sub> Yes   <input type="checkbox"/><sub>0</sub> No</p> <p><input type="checkbox"/><sub>1</sub> Participant had marked difficulty or requires 4 corrections on the two practice lines.</p> <p><input type="checkbox"/><sub>2</sub> Ran out of time.</p> <p><input type="checkbox"/><sub>3</sub> Participant declined to continue</p> <p><input type="checkbox"/><sub>4</sub> Eyesight difficulties</p> <p><input type="checkbox"/><sub>5</sub> Reading difficulties</p> <p><input type="checkbox"/><sub>6</sub> Test abandoned by assessor due to marked difficulty in the first two conditions (if selected do not show condition 4)</p>
<p><b>426. Condition 3: Inhibition</b></p> <p>NOTE: condition for variable being shown, should be Shown if 425. is Yes.</p> <p>a. Total Uncorrected Errors (Max=50)</p> <p>b. Total Self-Corrected Errors (Max=50)</p> <p>c. [CWIT.3c] Total Time to Complete</p> <p>(Note: if participant ran out of time/&gt;180s, then enter 180s.)</p>	<p>__ __ uncorrected errors</p> <p>__ __ self-corrected errors</p> <p>__ . __ seconds (Max=180seconds)</p>

# ADVANCE STUDY – CLINICAL REPORT FORM

A	D	V				
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ADV number

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4 letter code

## ADVANCE - Traumatic Brain Injury (TBI)

**427. Was the D-KEFS Colour-Word Interference Test, Condition 4: Inhibition/Switching completed?**

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Participant had marked difficulty or did not finish before the time limit was reached on condition 3.
- ☐<sub>2</sub> Participant has marked difficulty or requires 4 corrections from the two practice lines.
- ☐<sub>3</sub> Ran out of time.
- ☐<sub>4</sub> Participant refused to continue
- ☐<sub>5</sub> Eyesight difficulties
- ☐<sub>6</sub> Reading difficulties

**428. Condition 4: Inhibition/Switching**

NOTE: condition for variable being shown, should be Shown if 427. is Yes.

**a. Total Uncorrected Errors (Max=50)**

**b. Total Self-Corrected Errors (Max=50)**

**c. [CWIT.4c] Total Time to Complete**

(Note: if participant ran out of time/>180s, then enter 180s.)

\_\_ . uncorrected errors

\_\_ . self-corrected errors

\_\_ . \_\_ seconds (Max=180seconds)

**[CWIT.5] Combined Naming + Reading**

(formula= (CWIT.1c+CWIT.2c)/2)

[Calculated field]

\_\_ . \_\_

**[CWIT.6] Inhibition vs. Colour Naming**

(formula= CWIT.1c-CWIT.3c)

[Calculated field]

\_\_ . \_\_

**[CWIT.7] Inhibition/Switching vs. Combined Naming + Reading**

(formula= CWIT.3c-CWIT.5)

[Calculated field]

\_\_ . \_\_

**[CWIT.8] Inhibition/Switching vs. Inhibition**

(formula= CWIT.4c-CWIT.3c)

[Calculated field]

\_\_ . \_\_

## RBANS (Repeatable Battery for the Assessment of Neuropsychological Status)

**429. Was the RBANS List Learning test completed?**

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time
- ☐<sub>2</sub> Participant declined to continue

**430. List Learning Total Score =**

(NOTE: condition for variable being shown, should be shown if 429. is YES.)

\_\_ (Range=0-40)

**431. Was the RBANS Story Memory test completed?**

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time
- ☐<sub>2</sub> Participant declined to continue

**432. Story Memory Total Score=**

(NOTE: condition for variable being shown, should be shown if 431. is YES.)

\_\_ (Range= 0-24)

**433. Was the RBANS Figure Copy test completed?**

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time
- ☐<sub>2</sub> Participant declined to continue

# ADVANCE STUDY – CLINICAL REPORT FORM

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## ADVANCE - Traumatic Brain Injury (TBI)

☐<sub>3</sub> Eyesight difficulties

### 434. Figure Copy Total Score =

(NOTE: condition for variable being shown, should be shown if 433. is YES.)

\_\_ (Range=0-20)

### 435. Was the RBANS Line Orientation test completed?

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time  
☐<sub>2</sub> Participant declined to continue  
☐<sub>3</sub> Eyesight difficulties

### 436. Line Orientation Total Score =

(NOTE: condition for variable being shown, should be shown if 435. is YES.)

\_\_ (Range=0-20)

### 437. Was the RBANS Picture Naming test completed?

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time  
☐<sub>2</sub> Participant declined to continue  
☐<sub>3</sub> Eyesight difficulties

### 438. Picture Naming Total Score =

(NOTE: condition for variable being shown, should be shown if 437. is YES.)

\_\_ (Range=0-10)

### 439. Was the RBANS Semantic Fluency test completed?

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time  
☐<sub>2</sub> Participant declined to continue

### 440. Semantic Fluency Total Score=

(NOTE: condition for variable being shown, should be shown if 439. is YES.)

\_\_ (Range=4-40)

### 441. Was the RBANS Digit Span test completed?

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time  
☐<sub>2</sub> Participant declined to continue

### 442. Digit Span Total Score =

(NOTE: condition for variable being shown, should be shown if 441. is YES.)

\_\_ (Range=0-16)

### 443. Was the RBANS Coding test completed?

If NO, select from options

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time  
☐<sub>2</sub> Participant declined to continue  
☐<sub>3</sub> Eyesight difficulties  
☐<sub>4</sub> Reading difficulties

### 444. Coding Total Score=

(NOTE: condition for variable being shown, should be shown if 443. is YES.)

\_\_ (Range=0-89)

### 445. Was the RBANS List Recall test completed?

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

- ☐<sub>1</sub> Ran out of time  
☐<sub>2</sub> Participant declined to continue



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## ADVANCE - Traumatic Brain Injury (TBI)

<b>446. List Recall Total Score =</b> <small>(NOTE: condition for variable being shown, should be shown if 445. is YES.)</small>	__ __ (Range=0-10)
<b>447. Was the RBANS List Recognition test completed?</b>  If NO, select from options.	<div style="text-align: right;"> <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>0</sub> No                 </div> <div> <input type="checkbox"/><sub>1</sub> Ran out of time  <input type="checkbox"/><sub>2</sub> Participant declined to continue                 </div>
<b>448. List Recognition Total Score =</b> <small>(NOTE: condition for variable being shown, should be shown if 447. is YES.)</small>	__ __ (Range=0-20)
<b>449. Was the RBANS Story Recall test completed?</b>  If NO, select from options.	<div style="text-align: right;"> <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>0</sub> No                 </div> <div> <input type="checkbox"/><sub>1</sub> Ran out of time  <input type="checkbox"/><sub>2</sub> Participant declined to continue                 </div>
<b>450. Story Recall Total Score=</b> <small>(NOTE: condition for variable being shown, should be shown if 449. is YES.)</small>	__ __ (Range=0-12)
<b>451. Was the RBANS Figure Recall test completed?</b>  If NO, select from options.	<div style="text-align: right;"> <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>0</sub> No                 </div> <div> <input type="checkbox"/><sub>1</sub> Ran out of time  <input type="checkbox"/><sub>2</sub> Participant declined to continue  <input type="checkbox"/><sub>3</sub> Eyesight difficulties                 </div>
<b>452. Figure Recall Total Score</b> <small>(NOTE: condition for variable being shown, should be shown if 451. is YES.)</small>	__ __ (Range=0-20)

### Score Conversion Page

Use Appendix 2 in the Stimulus Book to convert Total Scores to Index Scores and Sum of Index Scores to Total Scale. Subtest scaled scores and cumulative percentages are also available.

<b>453. Immediate Memory Index Score=</b> __ __ __ (Range=40-152)	
<b>454. Visuospatial/Constructional Index Score =</b> __ __ __ (Range=50-136)	
<b>455. Language Index Score=</b> __ __ __ (Range=40-137)	
<b>456. Attention Index Score=</b> __ __ __ (Range=40-154)	
<b>457. Delayed Memory Index Score=</b> __ __ __ (Range=40-137)	
Only show if participants have been able to complete all tests in the RBANS (429-452.) <b>(Sum index and total scale won't be relevant if participant is unable to do all tests.)</b>	
<b>458. Total Index (Sum all index score)=</b>	__ __ __

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## ADVANCE - Traumatic Brain Injury (TBI)

459. Total Scaled Score=

460. Confidence interval 95% of Total Scaled Score=

461. Percentile=

---  
--- - ---  
---. --- %

### Dot Counting

462. Was the Dot Counting completed?

If NO, select from options, and move to 467. (CogAssess).

☐<sub>1</sub> Yes ☐<sub>0</sub> No

☐<sub>1</sub> Ran out of time.  
☐<sub>2</sub> Participant declined to take part  
☐<sub>3</sub> Eyesight difficulties

463. Cards 1-6 Total Response Time=

---. --- seconds

[DCT1] Mean UG Time = [q463] /6.  
[Calculated field]

---. --- seconds

464. Cards 7-12 Total Response Time=

---. --- seconds

[DCT2] Mean G Time = [q464]/6.  
[Calculated field]

---. --- seconds

465. [DCT3] Total Errors

---

466. E-Score = [DCT1] + [DCT2] + [DCT3].  
[Calculated field]

---. ---

### CogAssess – Tablet Neuropsychological Tests

467. Which tablet was used for the assessment?

☐<sub>1</sub> ☐<sub>2</sub> ☐<sub>3</sub> ☐<sub>4</sub> ☐<sub>5</sub>

468. Was the Choice reaction time' test completed?

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

☐<sub>1</sub> Ran out of time.  
☐<sub>2</sub> Participant declined to take part  
☐<sub>3</sub> Eyesight difficulties  
☐<sub>4</sub> Technical difficulties with tablets.

469. Was the Simple reaction time completed?

If NO, select from options.

☐<sub>1</sub> Yes ☐<sub>0</sub> No

☐<sub>1</sub> Ran out of time.  
☐<sub>2</sub> Participant declined to take part  
☐<sub>3</sub> Eyesight difficulties  
☐<sub>4</sub> Technical difficulties with tablets.

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## ADVANCE STUDY – CLINICAL REPORT FORM

### MRI Scan Results

**470. Was the MRI completed?**

If NO, please select from options.  
(NOTE: If NO, do not show remainder of section)

☐<sub>1</sub> Yes    ☐<sub>0</sub> No

- ☐<sub>1</sub> Participant is ineligible for MRI Scan
- ☐<sub>2</sub> Participant declined to continue
- ☐<sub>3</sub> Department closed/Staffing shortage
- ☐<sub>4</sub> Technical problems with Scanner
- ☐<sub>5</sub> Not booked/slots unavailable

**Date:**

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

**Time:**

\_\_ \_\_ : \_\_ \_\_ (24hrs)

**472. MRI done by**

\_\_\_\_\_  
Radiographer name

**473. Has participant been signed off in accordance with the MRI safety checklist as fit to have an MRI scan by a radiologist?**

☐<sub>1</sub> Yes    ☐<sub>0</sub> No

**Safety Questionnaire completed by:**

\_\_\_\_\_  
(Radiographer name)

**474. Were all scans completed?**

If NO, please select which scans WERE completed.

☐<sub>1</sub> Yes    ☐<sub>0</sub> No

- ☐<sub>1</sub> Volumetric T1
- ☐<sub>2</sub> SWI
- ☐<sub>3</sub> T2 FLAIR
- ☐<sub>4</sub> Diffusion MRI
- ☐<sub>5</sub> Resting state functional MRI

**475a. What head coil was used?**

- ☐<sub>1</sub> 16 channel
- ☐<sub>2</sub> 32 channel

**475. Please select from the following options as to why the scans were not completed.**

(Note: Only shown if 474. is No.)

- ☐<sub>1</sub> Participant declined to continue
- ☐<sub>2</sub> Ran out of time
- ☐<sub>3</sub> Technical problems with Scanner
- ☐<sub>4</sub> Participant taken ill
- ☐<sub>5</sub> Participant is claustrophobic
- ☐<sub>6</sub> Participant unable to keep still

## ADVANCE STUDY – CLINICAL REPORT FORM

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<b>476. Does the participant require a rescheduled appoint to complete unfinished tests?</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
<b>477. Scans transferred via IEP to the Imperial Health trust.</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
<b>478. Scan transfer completed by:</b>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> (Radiographer name)									
<b>479. Date scan was transferred:</b>	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center; font-size: small;"> <tr> <td style="width: 12.5%;">D</td><td style="width: 12.5%;">D</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">Y</td><td style="width: 12.5%;">Y</td><td style="width: 12.5%;">Y</td><td style="width: 12.5%;">Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
<b>480. Clinical report received.</b>	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
<b>481. Completed by:</b>	<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div>									
<b>482. Date report was received:</b>	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center; font-size: small;"> <tr> <td style="width: 12.5%;">D</td><td style="width: 12.5%;">D</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">Y</td><td style="width: 12.5%;">Y</td><td style="width: 12.5%;">Y</td><td style="width: 12.5%;">Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
<b>483. MRI clinical report conclusion:</b>	<div style="margin-bottom: 10px;"> <input type="checkbox"/><sub>1</sub> In your case the scan showed: No significant abnormalities. No further action is required.         </div> <div style="margin-bottom: 10px;"> <input type="checkbox"/><sub>2</sub> In your case the scan showed:           <div style="border-bottom: 1px solid black; margin-top: 5px;"></div> </div> <p style="font-size: small;">No medical action is needed based on these findings, which we are letting you know for your information only. We will copy this to your GP/MO, so they are aware. If, however you have any concerns about what the scan report means, or want to discuss it further, do please contact us on (<a href="mailto:dmrc-advancestudyteam@mod.gov.uk">dmrc-advancestudyteam@mod.gov.uk</a>) or your doctor.</p> <div style="margin-bottom: 10px;"> <input type="checkbox"/><sub>3</sub> In your case the scan showed:           <div style="border-bottom: 1px solid black; margin-top: 5px;"></div> </div> <div> <input type="checkbox"/><sub>4</sub> No MRI scan performed.         </div>									
<b>484. MRI clinical report uploaded to:</b> <div style="margin-left: 20px;"> <ul style="list-style-type: none"> <li>DMICP</li> <li>RIS</li> </ul> </div>	<div style="margin-bottom: 10px;"> <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>0</sub> No         </div> <div> <input type="checkbox"/><sub>1</sub> Yes    <input type="checkbox"/><sub>0</sub> No         </div>									

### Section Tx: Participant Questionnaire checkpoint

**300. Has the Participant Questionnaire (P.Q. FU1) been completed?**

☐<sub>1</sub> Yes  
☐<sub>0</sub> No

**If not, please give details**

# ADVANCE STUDY – CLINICAL REPORT FORM

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## Section U: ADVERSE EVENTS - Make multiple copies of this page if required

148. Is there an Adverse event to report?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
149. Adverse event name	<hr/>									
150. Intensity	<input type="checkbox"/> <sub>1</sub> Mild <input type="checkbox"/> <sub>2</sub> Moderate <input type="checkbox"/> <sub>3</sub> Severe									
151. If SAE specify:	<input type="checkbox"/> <sub>1</sub> Death (record date below) <input type="checkbox"/> <sub>2</sub> Life-threatening <input type="checkbox"/> <sub>3</sub> Persistent or symptomatic disability or incapacity <input type="checkbox"/> <sub>4</sub> Hospitalisation or prolongation of hospitalisation <input type="checkbox"/> <sub>5</sub> Congenital anomaly or birth defect <input type="checkbox"/> <sub>6</sub> Other important medical event									
152. Date Event Occurred	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
153. Date Resolved	<table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table> OR <input type="checkbox"/> Ongoing at the end of visit	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
154. Is this event related to procedures performed for the ADVANCE study?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
155. Has participation in the ADVANCE study caused this event?	<input type="checkbox"/> <sub>1</sub> Yes <input type="checkbox"/> <sub>0</sub> No									
156. Was this event an expected result from a procedure administered?	<input type="checkbox"/> <sub>1</sub> Certain <input type="checkbox"/> <sub>2</sub> Probable <input type="checkbox"/> <sub>3</sub> Unlikely <input type="checkbox"/> <sub>4</sub> Not related									

157. Clinician's Comments:

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<b>A</b>	<b>D</b>	<b>V</b>				
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## SECTION V: BLOOD & URINE

**158. Was URINE sample obtained:**

<input type="checkbox"/> <sub>1</sub> Yes	Date taken: <table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
<input type="checkbox"/> <sub>0</sub> No	If no, give reason:									

**159. Was BLOOD sample obtained:**

<input type="checkbox"/> <sub>1</sub> Yes	Date taken: <table border="1"> <tr> <td>D</td><td>D</td><td>M</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td> </tr> </table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
<input type="checkbox"/> <sub>0</sub> No	If no, give reason: <input type="checkbox"/> <sub>1</sub> Participant declined <input type="checkbox"/> <sub>2</sub> Unable to bleed <input type="checkbox"/> <sub>3</sub> Other (specify):									

**All blood results available?**

FBC	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
Lipids	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
Glucose	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
LFT	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
Urea & Electrolytes	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
Sex Hormones	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No
Creatinine	<input type="checkbox"/> <sub>1</sub> Yes	<input type="checkbox"/> <sub>0</sub> No

If 'no' to any of the above, please provide a reason




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<b>160. Clinician's Initials</b>					
<b>FBC</b>	161. HB	<input type="text"/> <input type="text"/> <input type="text"/> g/l	<b>Glucose</b>	174. fasting glucose	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mmol/l
	162. WBC	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> 10 <sup>9</sup> /l		175. HbA1C	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mmol/l
	163. platelets	<input type="text"/> <input type="text"/> <input type="text"/> 10 <sup>9</sup> /l	<b>LFT</b>	176. ALT	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> u/l
	164. neutrophils	<input type="text"/> . <input type="text"/> 10 <sup>9</sup> /l		177. ALP	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> u/l
	165. lymphocytes	<input type="text"/> . <input type="text"/> 10 <sup>9</sup> /l		178. albumin	<input type="text"/> <input type="text"/> g/l
	166. eosinophils	<input type="text"/> . <input type="text"/> <input type="text"/> 10 <sup>9</sup> /l		179. bilirubin	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> umol/l
	167. basophils	<input type="text"/> . <input type="text"/> <input type="text"/> 10 <sup>9</sup> /l		180. gamma GT	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> u/l
<b>Lipids</b>	168. cholesterol (CHL)	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mmol/l	<b>Urea &amp; Electrolytes</b>	181. sodium	<input type="text"/> <input type="text"/> <input type="text"/> mmol/l
	169. HDL	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mmol/l		182. potassium	<input type="text"/> . <input type="text"/> mmol/l
	170. LDL	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mmol/l		183. urea	<input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> mmol/l
	171. triglycerides	<input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> mmol/l		184. creatinine	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mmol/l

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	172. non-HDL CHL	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mmol/l	<div>185. <b>eGFR</b> <input type="text"/><input type="text"/> ml/min (if readings less than 90)</div> <div>or <input type="checkbox"/> (TICK if readings 90 or more)</div>	
	173. HDL/CHL ratio	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> mmol/l		
<b>HSCRP</b>	186. HSCRP	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
<b>Sex Hormones</b>	188. Testosterone	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> nmol/L	190. Follicular-stimulating hormone (FSH)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> U/L
	189. Sex hormone binding globulin (SHBG)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> nmol/L	191. Luteinizing hormone (LH)	<input type="text"/> <input type="text"/> <input type="text"/> U/L

## Section W: Blood and Urine storage

			Amount (# cryovials)			
			Please identify number of cryovials stored by ticking the relevant box(es)			
<b>192. Serum</b>	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
<b>193. Plasma</b>	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
<b>194. WB</b>	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	
<b>195. Urine</b>	Yes <input type="checkbox"/> <sub>1</sub>	No <input type="checkbox"/> <sub>0</sub>	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	
<b>196. Whatman Card</b> Only if missing from baseline		<input type="checkbox"/> <sub>1</sub> Yes, as not taken at baseline <input type="checkbox"/> <sub>0</sub> No, taken at baseline				

# ADVANCE STUDY – CLINICAL REPORT FORM

A	D	V				
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ADV number

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4 letter code

## Section X: FINAL 3 YEAR VISIT OUTCOME

197. Has participant completed 3 Year Follow Up (Questionnaire or CRF)?

☐<sub>1</sub> Yes

(198) Completion date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

☐<sub>0</sub> No (199) If NOT completed, specify last follow up date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

200. Reason not completed:

☐<sub>1</sub> Consent withdrawn

☐<sub>2</sub> Lost to follow-up

☐<sub>3</sub> Other (specify) \_\_\_\_\_

(Tick only **one** box)

201. Remarks:

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## Section Y: Clinician's Statement:

I have reviewed the data recorded in this CRF and confirm that the data are complete and accurate

202. Clinician (Signature): \_\_\_\_\_

203. Clinician (Full name): \_\_\_\_\_

204. Signature Date:

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

## Results Letters:

205. Letter completed by: \_\_\_\_\_

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

206. Letter Q.C.'ed by: \_\_\_\_\_

D	D	M	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---

207. Email / Post sent by: \_\_\_\_\_

D	D	M	M	M	Y	Y	Y	Y
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