



P I S C E S

Entry Form/Checklist

Centre No:

Patient ID

P.I Name (Principal Investigators name)

Gender

Male	Female
<input type="checkbox"/>	<input type="checkbox"/>

D.O.B (DD/MM/YY)

Baseline BP at entry

<input type="text"/>
<input type="text"/>

Has patient got stuttering priapism?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Has patient information leaflet been given?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Has written consent been obtained?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Randomisation completed

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Has Phase A diary given?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Date given

Has Phase B diary given?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Date given

Date started drugs allocated

Has Guthrie Card blood sample been taken?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Genotype confirmed

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>

Type

Hb

Diary Checks

Phase A

Date

Signed

BP

Week 1 (Entry)

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Week 6

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Week 12

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Week 18

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Week 24

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Randomisation Number

Phase B

Week 30

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Week 36

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Week 42

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Week 48

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Week 52:

Diary sent to Central Office

Yes/No