RCT ON THE MANAGEMENT OF EARLY PREGNANCY FAILURE
UNSCHEDULED STUDY VISIT

Site	Patient No.	Letter Code	Visit	Sequence
		0 0		

A. BASIC INFORMATION

1. Date of Visit: __ __ __ - __ __ - _2_ _0_ _0_ __ (Month Day Year) FM10DT

OBTAIN MEDICAL RECORDS

2. Site: (Choose One)

Research Clinic	(1)	UVSITE
Emergency Room	(2)	
Outpatient Clinic	(3)	
Personal Physician's Office	(4)	
Health Department	(5)	
Other	(6)	

If other, specify _____ UVSITESP

3. Reason(s) for this visit (according to patient's chief complaints. Choose all that apply).

		Yes	No	
A.	Heavy Bleeding	(1)	(2)	UVRSBLD
B.	Extreme Abdominal Pain	(1)	(2)	UVRSAPN
C.	Fever	(1)	(2)	UVRSFEV
D.	Nausea/Vomiting	(1)	(2)	UVRSNAUS
E.	Diarrhea	(1)	(2)	UVRSDIAR
F.	Emotional Need	(1)	(2)	UVRSEMOT
G.	Other	(1)	(2)	UVRSOTH

If other, specify _____ UVRS_SP

IF REASON IS ANY OF A TO F, COMPLETE FORM 03 – PHYSICAL EXAMINATION, LABORATORY ASSESSMENT AND TRANSVAGINAL ULTRASOUND.

B. **DIAGNOSIS AND TREATMENT**

	Yes	No	
MEDICAL RECORDS OBTAINED?	(1)	(2)	UVMEDREC

If Yes, Answer B1. If No, Skip to B2.

1. Diagnosis:

		Yes	No	
A.	Heavy Bleeding	(1)	(2)	UVDXBLD
B.	Extreme Abdominal Pain	(1)	(2)	UVDXAPN
C.	Febrile Reaction	(1)	(2)	UVDXFEV
D.	Nausea/Vomiting	(1)	(2)	UVNAUS
E.	Infection	(1)	(2)	UVDXINF
F.	Emotional Need	(1)	(2)	UVDXEMOT
G.	Other	(1)	(2)	UVOTH

If other, specify _____ UVDX_SP

2. Treatment given:

None	(1)	UVTRT
D&C	(2)	
Other	(3)	
Unknown	(4)	

If other, specify: _____ UVTRT_SP

IF D&C, COMPLETE FORM 06.

C. ADMINISTRATIVE MATTERS

1. Comments: GEN_CMNT _____

2. Person completing form: CERT_SIG _____ Staff Number CERT_NO __ __ __ - __ __ __

3. Date form completed: ___ ___ ___ - ___ ___ - 2 0 0 ___ COMPL_DT
Month Day Year