

End of Study Case Report Form

A. Study Completion										
1. Date of study termination:	<table border="1" style="display: inline-table; text-align: center;"><tr><td style="width: 20px; height: 20px;">D</td><td style="width: 20px; height: 20px;">D</td><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y		
2. Reason for study termination:										
<input type="checkbox"/> Routine study termination, study protocol completed <input type="checkbox"/> Early study termination, due to: <ul style="list-style-type: none"> <input type="checkbox"/> Lost to follow up <input type="checkbox"/> Death* <input type="checkbox"/> Withdrawal of subject's consent**: <ul style="list-style-type: none"> <input type="checkbox"/> Subject allows data collection to continue <input type="checkbox"/> Subject refuses further data collection <input type="checkbox"/> Other, please specify: _____ 										
*If selected, please complete Death Outcome Form and SAE form										
**Reason(s) subject has withdrawn consent:										

B. Suspected Secondary Outcome Events						
1. Did the subject have one or more suspected outcome events listed below that will undergo adjudication? (check all that apply)*:						
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> None</td> <td style="width: 33%;"><input type="checkbox"/> Symptomatic venous thromboembolism</td> <td style="width: 33%;"><input type="checkbox"/> Bleeding/Hematoma</td> </tr> <tr> <td><input type="checkbox"/> Death*</td> <td><input type="checkbox"/> Symptomatic arterial thromboembolism</td> <td><input type="checkbox"/> Postpartum pre-eclampsia</td> </tr> </table>	<input type="checkbox"/> None	<input type="checkbox"/> Symptomatic venous thromboembolism	<input type="checkbox"/> Bleeding/Hematoma	<input type="checkbox"/> Death*	<input type="checkbox"/> Symptomatic arterial thromboembolism	<input type="checkbox"/> Postpartum pre-eclampsia
<input type="checkbox"/> None	<input type="checkbox"/> Symptomatic venous thromboembolism	<input type="checkbox"/> Bleeding/Hematoma				
<input type="checkbox"/> Death*	<input type="checkbox"/> Symptomatic arterial thromboembolism	<input type="checkbox"/> Postpartum pre-eclampsia				
*If yes, please ensure corresponding Outcome Event and SAE form(s) are completed.						

Delegate's Name:									
Signature:									
I have reviewed all entries on the Case Report Forms. All information entered onto the Case Report Form for this subject is, to the best of my knowledge, correct.									
Investigator's Name:									
Signature:									
Date: <table border="1" style="display: inline-table; text-align: center;"><tr><td style="width: 20px; height: 20px;">D</td><td style="width: 20px; height: 20px;">D</td><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">M</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td><td style="width: 20px; height: 20px;">Y</td></tr></table>	D	D	M	M	M	Y	Y	Y	Y
D	D	M	M	M	Y	Y	Y	Y	