Effectiveness of Leukotriene receptor antagonists in the EValuation of Asthma Therapies and for health Economics Tel: 01603 - 591106 or - 593309



THIS CRF IS FOR PATIENTS ON INHALED CORTICOSTEROIDS ONLY PRIOR TO STUDY This patient will start on STEP 3 in ELEVATE

| Study identification no.: Patie | ent initials | Date:// |
|--|-----------------|---|
| Please confirm: | | |
| Patient meets all inclusion criteria (as listed on audit sheet) | Yes 🗌 | If criteria failed, stop, but call study office if |
| Patient does not have any exclusion criteria (as listed on audit sheet) | Yes 🗌 | you think patient should be in study |
| Patient information sheets reviewed and informed consent obtained? | Yes 🗌 | |
| DEMOGRAPHY – complete with patient | | |
| Sex : Male Female Postcode: | Date of birth: | |
| Race: White Mixed Asian | Black Chir | nese Other |
| Did education continue after minimum school leaving | age? | Yes No |
| Does patient have a degree or equivalent professional | qualification? | Yes No |
| Which of following best describes patient's main activ | rity? | (tick one) |
| • employment or self-employment. Specify job design | cription below. | |
| • retired Specify last main job description below. | | |
| • housework | | |
| • student | | |
| seeking work | | |
| • other, specify here | | |
| Job Description If answer "employed or self employed 1. Tick appropriate box for: employer, self-employed properties of the control of the co | | employer \Box |
| employees) or employee. 2. In space below, specify: | yea (without | self-employed (without employees) |
| | | employee \square |

(.... Visit 1 continues on next page....)

| Patient ID # | Initials | date | _/ | / | _ time: | |
|--|--|-----------------|---------------|-------------|-------------------------|-------------------------|
| PEF (no inhaled β-a | gonist for 4 hours if possible |) | | | | |
| Tick if las | t β-agonist was more thar | n 4 hours ag | go:[| | | |
| Tick if last β-agor | nist less than 4 hours (& sta | ate time of do | se) | Tir | ne::_ | _ |
| PEF | | | 1 | st reading | 2 nd reading | 3 rd reading |
| | | | | L/m | L/m | L/m |
| Symptoms during the last for | r weeks: | | | ŀ | f yes, how often? | |
| difficulty sleeping because | of asthma symptoms (including cough |))? | | Yes 🗌 No (d | ays per week 0-7) _ | |
| had usual asthma sympton | ns (cough, wheeze, chest tightness, so | ob) during day? | | | ays per week 0-7) | |
| | usual activities (e.g. housework, work | , | | Yes 🗌 No (d | ays per week 0-7) _ | |
| Physical exam | | | | normal | abnormal | not done |
| Specify any abnorm | alities: | | | | | |
| | | | | | | |
| Height: | | | | | cms | i |
| | Other steps to be complete | d at this stag | e of | thic vicit | | |
| a) All medications n | rescribed in previous 3 mo | | $\overline{}$ | | | |
| | see red tab at back of CR | | ucu (| or the | | |
| b) Give Symptom D use. (see opposite) | iary forms to patient and ir | nstruct patie | ent ir | n their | | |
| - | t they should not, if possible, of course they may use the I | | | | | |
| | ontact information sheet. Re elope along with top copy of | | EVA | TE | | |
| | | | | | | |
| Note: If patient clinic | nent date - 2 weeks. cally has to have their ther 2 immediately – see instru | | sed* | now, | | |
| | We recommend that | patients | sho | uld foll | ow | |
| r | national guidelines or | n asthma | ma | nageme | ent. | |
| | ult their GP/nurse, as norr | mal, at any t | time | during th | e study | |
| Name of practitioner s and completing this fo | | | | | | |
| and completing this to | | | | | | - |
| | s of this page and previo | | | | | |

| Patient ID # PEF (no inhaled ß- | # Initials date agonist for 4 hours if possible) | e | _// | | time: | | |
|--|--|-------------------|-----------------|---------------------|--------|-----------------|---------|
| ` | β-agonist was more than 4 hours ago: | | | | | | |
| Tick if last β-agonis | st less than 4 hours (& state time of dose) | | | | Time _ | | |
| PEF | | 1 st r | reading | 2 nd rea | ading | 3 rd | reading |
| | | | _L/m | | L/m | | L/m |
| | g administer β-agonist now, and complete | Tin | ne drug g | given | | : | |
| following 3 pages wl | hile waiting. | Dru | ıg & dos | age | | | |
| MEDICAL HIST | ORY | | | | | | |
| CATEGORY | MEDICAL HISTORY TERM | | YEAR DIAGN | _ | - | СТ | IVE? |
| Active | Asthma | | | | No [| | Yes 🗌 |
| Medical | | | | | No 🗆 | | Yes 🗌 |
| Conditions | | | | | No 🗆 | | Yes 🗌 |
| & | | | | | No [| | Yes 🗌 |
| Significant Past Medical | | | | | No 🗆 | | Yes 🗌 |
| History | | | | | No 🗆 | | Yes 🗌 |
| (not minor illnesses) | | | | | No L | | Yes 🗌 |
| | | | | | No L | | Yes 🗌 |
| Drug Allergies: | | | | | | | |
| | | | YE | ΔR | DE | CII | LT OR |
| Respiratory and other | | | (Or "I never | VA" if | | | COME |
| investigations or procedures: | Allergy skin prick test | | | | | | |
| e.g. Lab tests | IgE / RAST | | | | | | |
| if clinically significant or | chest x-ray(s) (any abnormal or latest | () | | | | | |
| abnormal. | | | | | | | |
| e.g. Surgery, or procedures, if relevant | | | | | | | |
| Comments: | | | | | | | |

(....Visit 2 continues on next page....)

| | Patient ID # Initials_ | date | <u> </u> | _ time: | |
|-----|--|----------------------|---------------|-----------------|-------------|
| Bas | seline Asthma Profile - FROM CL | | (may confirm | with patient if | required) |
| 1. | Is diagnosis of asthma recorded in c | | ☐ Yes | ☐ No | |
| | is for diagnosis is: | (tick ☑ any or | | | |
| A) | Reversibility after inhaled β-agonist | | ☐ PEF c | or FEV1 | |
| | date | | | | |
| | value pre medication | | | | |
| | value post medication | | | | |
| | % change | | | | |
| Β, | other, specify | | | | |
| B) | PEF variability | | | | |
| | date | | | | |
| | highest PEF | | | | |
| | lowest PEF | | | | |
| | % change | | | | |
| | other, specify | | | | |
| C) | Response to other treatment (eg ICS | trial), specify: | | | |
| | | | | | |
| | | | | | |
| D) | Physician diagnosis, based on history | and and | | | |
| | examination, specify: | | | | |
| | | | | | |
| E) | Other, specify: | | | | |
| , | | | | | |
| | | | | | |
| 2. | Does patient have asthma symptoms | brought on by: | | | |
| ۷. | | brought on by. | | | |
| | exercise or physical activity | | Yes | No | |
| | viral infections | | Yes | No | |
| | cold air | | Yes | No | |
| | animals, specify | | Yes | No | |
| | occupation, specify | | Yes | No |) |
| | aspirin or other NSAID | | Yes | No | ס |
| | others, specify | | ∐Yes | ∐ No |) |
| 2 | Constring the the resting to some smaller do | | | | |
| 3. | Smoking has the patient ever smoked? | 11.0 | | moked) | no, (never) |
| | | tient start smoking? | age: | | |
| | average number | of cigarettes daily? | | | |
| | other, e.g. pipe, roll-ups, cigar | rs. Specify: | | | |
| | | | | | |
| | Still smoking? | [] no (-tt) | Vioc. (-111 | 11 am alsa-) | 1 7 7 |
| | | no, (stopped) | | ll smokes) | V |
| | What age did patient stop smoking? | age: | next question | 1 | next |
| | | | " question | • | auestion |

| Patient ID # | Initials | date | | | time: | |
|--|--|---------------|------------------------|--------|-------------------------|------------------------|
| a) Ask patient for Symptom and com | Diary Card, check if pleted. Post it to UEA | | derstood | | | |
| b) Record all medications cl (see red | hanges, since Visit 1, of tab at back of CRF). | on medication | ons sheet | | | |
| c) Give visit 2 Questionnair numbers) and Freepost env returned to UEA (see oppo | velopes to patient to | | | | | |
| Explain Patient oriented tar | gets | | | | | |
| d) Complete Resource Data | a Collection Sheet wi | ith patient | (also use | | | |
| clinical records). Give fridge | e magnet and Resour | ce Diary to | use until | | | |
| next visit, and explain. | | | | | | |
| Report reversibility test (a | at least 15 minutes | after β-ago | nist giv | en). | | |
| PEF | | | 1 st readir | ng : | 2 nd reading | 3 rd readin |
| | | | L/r | | L/m | L/n |
| Symptoms during the last four weeks: | | | | lf. | yes, how often? | |
| difficulty sleeping because of asthma | symptoms (including cough)? | | ☐ Yes ☐ N | lo (da | ys per week 0-7) | |
| had usual asthma symptoms (cough, | wheeze, chest tightness, sob) | during day? | | | ys per week 0-7) | |
| has asthma interfered with usual activ | ities (e.g. housework, work/sci | hool etc)? | ∐ Yes ∐ N | lo (da | ys per week 0-7) | |
| | | | | | | |
| Randomisation to treatme | ent arm (see opposit | e) | | | | |
| Arm A – Inhaled Ster | | | | | | |
| Arm B – Inhaled Ster | oid plus LTRA | | | |] | |
| Other steps to be completed o | n this visit: | | | | | |
| e) Study medication prescr | iption given by GP ar | nd recorded | I | | | |
| f) Patient pocket informatio | n card given to patie | nt | | | | |
| g) Put treatment arm sticke | r put on medical reco | ord (if appro | oriate) | | | |
| Date of next study appointr | nent - 2 months | | | | 1 | , |
| (+/- 3 weeks; may be provisio this to be done through normal practice) | | | vision for | - | · | ·—— |
| | ommend that pat guidelines on as | | | | | |
| Patient should consu | • | | • | | | dv |
| Name of practitioner seeing pa | | normal, at c | arry tirric | aun | ing the state | a y |
| and completing this for | | | | | | |
| Remove top copies of return to UEA, | this page and prev using Freepost en | | and | | | |

| Patient ID # Initials | aate | !! | time: | |
|---|-------------|-------------------------|--|-------------------------|
| | | face to fac | ce tel | ephone |
| | L | | | <u> </u> |
| PEF (no inhaled β-agonist for 4 hours if possible) | | | | |
| Tick if last β -agonist was more than 4 ho | ours ago: | | | |
| Tick if last $\beta\text{-agonist}$ less than 4 hours (& state times | ne of dose) | ☐ Ti | me::_ | |
| PEF | | 1 st reading | 2 nd reading | 3 rd reading |
| | | L/m | L/m | L/m |
| Symptoms during the last four weeks: difficulty sleeping because of asthma symptoms (including cough)? had usual asthma symptoms (cough, wheeze, chest tightness, sob) du has asthma interfered with usual activities (e.g. housework, work/school | - ' | ☐ Yes ☐ No (| If yes, how often? days per week 0-7) days per week 0-7) days per week 0-7) | |
| Other steps to be completed this visit: | | | | |
| Record all medication changes, since last study visit, o (see red tab at back of CRF). | n medicati | ons sheet | | |
| Confirm patient received questionnaire and returned to <i>study office to inform</i>). | UEA. (If | not, call | | |
| Complete Resource Data Collection form with pat records and Patient Resource Diary Card. (DO No updating it with any information that arises during | OT alter d | liary by | | |
| If patient's status changes (discontinuation or changes pregnant, discontinues contraception, or some or all follow up) fill status form (see green to and send copy to the UEA | r withdrav | vs from | | |
| If patient has any adverse event, fill in Adverse event yellow tab at the end of the CRF) and send copy to | | (see | | |
| | | · | - | |
| Date of next study appointment - 4 months | | | 1 | |
| (+/- 3 weeks; may be provisional) <i>Make appointment now, this to be done through normal practice appointing procedures.</i> | or make pro | vision for | | |
| We recommend that pat national guidelines on as | | | | |
| Patient should consult their GP/nurse, as | normal, a | t any time o | during the st | udy |
| Name of practitioner seeing patient and completing this form. | | | | _ |
| | | | | |

Remove top copies & return to UEA, using Freepost envelopes

| Patient ID # | Initials | date | | time: | | |
|---|---------------------------|----------------|-------------------------|--|-------------------------|--|
| | | | face to fa | ice te | lephone | |
| | | | | | <u> </u> | |
| PEF (no inhaled β-agonist for 4 | hours if possible) | | | | | |
| Tick if last β-agonist v | vas more than 4 h | nours ago: | | | | |
| Tick if last β-agonist less that | n 4 hours (& state ti | ime of dose) | T | ime::_ | | |
| PEF | | | 1 st reading | 2 nd reading | 3 rd reading | |
| | | | L/m | L/m | L/m | |
| Symptoms during the last four weeks: | | | | If yes, how often? | | |
| b difficulty sleeping because of asthma symp | , , | | | (days per week 0-7) (days per week 0-7) | | |
| had usual asthma symptoms (cough, whee | - | | | (days per week 0-7) (days per week 0-7) | | |
| has asthma interfered with usual activities | e.g. nousework, work/scri | 1001 etc) ? | | | | |
| | | | | | | |
| Other steps to be completed this v | risit: | | | | | |
| Record all medication changes, si | nce last study visit, | on medicati | ons sheet | | | |
| (see red tab at back of CRF). | | | | | | |
| Confirm patient received question | naire and returned | to UEA. (If | not, call | | | |
| study office to inform). | | | | | | |
| Complete Resource Data Colle records and Patient Resource | | | | | | |
| updating it with any information | | | | | | |
| If patient's status changes (dis | continuation or ch | ange of me | edication. | | | |
| becomes pregnant, discontinue | es contraception, | or withdrav | vs from | | | |
| some or all follow up) fill status | form (see green | tab at end | of CRF) | | | |
| and send copy to the UEA | at fill in Antonna a | | / | _ | | |
| If patient has any adverse ever yellow tab at the end of the CF | | | (see | | | |
| your tab at the one of the or | / ш сол сору | 10 02/1 | | _ | | |
| | | | | 1 | | |
| Date of next study appointmen | t - 6 months | | | | / | |
| (+/- 3 weeks; may be provisional) this to be done through normal practice | | w, or make pro | vision for | | | |
| | nmend that pa | itionte et | ould fol | low | | |
| | juidelines on a | | | | | |
| Patient should consult | | | • | | udv | |
| Name of practitioner seeing patien | | , | | <u> </u> | · J | |
| and completing this form. | | | | | _ | |
| | | | | | | |
| Remove top copies & return | to UEA, using F | reepost ei | rvelopes |] 🗆 | | |

| Patient ID # | Initials | date | | time: | |
|--|--|----------------|-------------------------|--|-------------------------|
| | | | face to fa | ace tele | phone |
| Annual Review - Demog Has patient's employment char If yes, complete the questions of | iged in the past year? | date page | Ye at the end o | | |
| Smoking update: Has patient stopped or started of the stopped or s | | ar? | sto | es No Dopped arted |] |
| and specify date | | | date : | | |
| PEF (no inhaled β-agonist for | 4 hours if possible) | | | | |
| Tick if last β-agonis | t was more than 4 ho | ours ago: | | | |
| Tick if last β-agonist less th | nan 4 hours (& state tim | ne of dose) | П | me::_ | |
| PEF | | | 1 st reading | 2 nd reading | 3 rd reading |
| | | | L/m | L/m | L/m |
| Symptoms during the last four weeks: | | | | If yes, how often? | |
| difficulty sleeping because of asthma sy had usual asthma symptoms (cough, w) has asthma interfered with usual activition | neeze, chest tightness, sob) du | | ☐ Yes ☐ No (| days per week 0-7) days per week 0-7) days per week 0-7) | |
| Other steps to be completed this | s visit: | | | | |
| Record all medication changes, sin red tab at back of CRF). | nce last study visit, on me | dications sh | neet (see | | |
| Confirm patient received question office to inform). | naire and returned to UEA | A. (If not, co | all study | | |
| Complete Resource Data Collectic Patient Resource Diary Card. (DO information that arises during this | NOT alter diary by upda | | | | |
| If patient's status changes (discont pregnant, discontinues contracepti fill status form (see green tab at en | llow up) | | | | |
| If patient has any adverse event, fi end of the CRF) and send copy to | | (see yellow | tab at the | | |
| Date of next study appointment - 6 | | | | / | / |
| (+/- 3 weeks; may be provisional) this to be done through normal pro | actice appointing procedu | ires. | | | |
| | Ve recommend that pational guidelines on ast | | | | |
| | nsult their GP/nurse, as no | | _ | the study | |
| Name of practitioner seeing pati and completing this form. | ent | | | | |
| Remove top copies & return to U | IEA, using Freenost env | elones | | П | |

| Patient ID # | Initials | date | / | _/ | tim | ne: | |
|--|--|-----------------|----------|---------------------|---------|--|-------------------------|
| | | | | fac | e to fa | ace tele | ephone |
| | | | | | | | <u> </u> |
| | onist for 4 hours if possi | | | Ι | | | |
| Tick if last | 3-agonist was more th | an 4 hour | s ago: | Ш | | | |
| Tick if last β-agonis | t less than 4 hours (& | state time o | of dose) | | Ti | me::_ | |
| PEF | | | | 1 st rea | ading | 2 nd reading | 3 rd reading |
| | | | | | L/m | L/m | L/m |
| had usual asthma symptoms | weeks: f asthma symptoms (including cost (cough, wheeze, chest tightness sual activities (e.g. housework, to | ss, sob) during | | ☐ Yes | □ No (| If yes, how often? days per week 0-7) days per week 0-7) days per week 0-7) | |
| Other steps to be comp | leted this visit: | visit. on r | nedicat | ions sh | neet | | |
| (see red tab at back of | | , | | | | | |
| Confirm patient receiv study office to inform). | ed questionnaire and retu | urned to U | EA. (If | not, ca | ıll | | |
| records and Patient I | Data Collection form v Resource Diary Card. nformation that arises | (DO NOT | alter o | liary b | | | |
| becomes pregnant, o | anges (discontinuation discontinues contracep) fill status form (see g e UEA | otion, or w | /ithdrav | vs fror | n | | |
| | verse event, fill in Adv of the CRF) and send | | | (see | | | |
| Date of next study ap | ppointment - 6 months | | | | | | 1 |
| | ovisional) Make appointment of the mal practice appointing proc | | nake pro | vision fo | or . | | |
| | Ve recommend the ational guidelines | - | | | | | |
| Patient shoul | d consult their GP/nur | se, as no | rmal, a | t any | time o | during the st | udy |
| Name of practitioner se and completing this for | | | | | | | _ |
| | | | | | | | |

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| Patient ID # | _ Initials | date | ll | time: | |
|---|----------------------|----------------|-------------------------|--|-------------------------|
| | | | face to fac | e tele | phone 🗌 |
| 1. DEMOGRAPHIC update Has the patient's employment ch If yes, complete the question | | | Ye page at the | | F |
| Smoking update: Has patient stopped or started smoking update: If yes, tick box for stopped or started | - | year? | | es No popped arted | |
| and specify date | | | da | ate :/_ | |
| PEF (no inhaled β-agonist for 4 ho | urs if possible) | | | | |
| Tick if last β-agonist w | as more than | 4 hours ago | p: 🗆 | | |
| Tick if last β-agonist less than | 1 4 hours (& sta | te time of dos | e) T i | me::_ | |
| PEF | | | 1 st reading | 2 nd reading | 3 rd reading |
| | | | L/m | L/m | L/m |
| Symptoms during the last four weeks: difficulty sleeping because of asthma sympton had usual asthma symptoms (cough, wheeze, has asthma interfered with usual activities (e.g. | chest tightness, sob |) during day? | ☐ Yes ☐ No(| If yes, how often? days per week 0-7) _ days per week 0-7) _ days per week 0-7) _ | |
| Physical exam | | | normal | abnormal | not done |
| Specify any abnormalities: Other steps to be completed this visi | t: | | | | |
| Record all medication changes, since (see red tab at back of CRF). | e last study visit | , on medicat | ions sheet | | |
| Confirm patient received questionna study office to inform). | ire and returned | to UEA. (If | not, call | | |
| Complete Resource Data Collect records and Patient Resource Di updating it with any information to | ary Card. DO | NOT alter d | | | |
| If patient's status changes (disco becomes pregnant, discontinues some or all follow up) fill status for and send copy to the UEA | contraception | , or withdrav | vs from | | |
| If patient has any adverse event, yellow tab at the end of the CRF, | | | (see | | |
| national gu | | asthma n | nanageme | ent. | |
| Patient should consult their GP/n Name of practitioner seeing patient | urse, as norma | ai, at any tin | ne auring th | e study | |
| and completing this form. | | | | | _ |
| Remove top copies & return t | o UEA, using | Freepost e | nvelopes | | |

Medications for Asthma:

& other respiratory problems or respiratory tract infections.

(For other – general - medications please use next page)

Post top copy to UEA after visit 3, post remaining copy after visit 7

| Post top copy to UEA after visit 3, post remaining copy after visit 7 | | | | | | | ر ما ^ا | |
|---|---|------------------------------|---|--------------------------------|----------------------------|---|-------------------|----------------------------|
| DRUG NAME | ROUTE | TOTA DAIL DOSA Dose | Y | START DATE (DD Mon-YYYY) | STOP DATE (DD Mon-YYYY) | WHY? If new: name of medical condition being treated – If dosage change: reason | Adverse Event? | Visit 7 only – continuing? |
| | | | | | | | If Yes | |
| | | | | | | | If Yes | |
| | | | | | | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | 1 1 | | If Yes | |
| | | | | | , , | | If Yes | |
| | | | | | | | If Yes | |
| | | | | | / / | | If Yes | |
| | | | | | / / | | If Yes | |
| *If any AE "YES" | *If any AE "YES" box is checked, complete the ADVERSE EXPERIENCE form (see yellow tab at end of CRF). | | | | | | | |

Drug Name: use generic name except: use trade name for fixed combinations only, and use trade name for medications with multiple active ingredients. **Route**: PO (oral), IV (intravenous infusion), IM (intramuscular), INH (inhalant), Other.

| Name of practitioner seeing patient | |
|-------------------------------------|--|
| and completing this form. | |

| | fe | or genera | al, non | n-asthma | a, non- | respiratory const remaining co | nditions. | | |
|-----------------|----------|------------------------------|----------|----------------------|-----------|--------------------------------|---|-------------------|--------------------------|
| DRUG NAME | ROUTE | TOTA DAIL DOSA Dose | AL .Y | STA DA (DD Mor | ART TE | STOP DATE (DD Mon-YYYY) | WHY? If new: name of medical condition being treated – If dosage change: reason | Adverse Event? | Visit 7 only continuing? |
| | | | | /_ | | | | If Yes | |
| | | | | / | / | | | If Yes | |
| | | | | , | , | 1 1 | | If Yes | |
| | | | | | | | | If Yes | |
| | | | | | | | | If Yes | |
| | | | | | | | | If Yes | |
| | | | | , | , | | | If Yes | |
| | | | | | | | | If Yes | |
| | | | | | | | | If Yes | |
| | | | | , | , | | | If Yes | |
| | | | | , | , | | | If Yes | |
| | | | | , | , | , , | | If Yes | |
| | | | | | | , , | | If Yes | |
| | | | | | , | , , | | If Yes | |
| *If any AE "VES | " hov is | checked . | comple | / | / | / | E form (see yellow tab at en | If Yes | <u> </u> |

Drug Name: use generic name except: use trade name for fixed combinations only, and use trade name for medications with multiple active ingredients. **Route:** PO (oral), IV (intravenous infusion), IM (intramuscular), INH (inhalant), Other.

| Name of practitioner seeing patient | |
|-------------------------------------|--|
| and completing this form. | |
| | |

| Date: | / / | Visit: | |
|-------|-----|--------|--|
| | | | |

Complete this page if there are changes in Employment Details

| (tick one) |
|---|
| |
| |
| |
| |
| |
| |
| |
| employer self-employed (without employees) |
| employee |
| // |
| |
| |

| ys and should be docume ge in medication, or follow than one may apply), ar Follow up data collection ication Continue as much | w up |
|--|---|
| collection ication Continue as much | |
| | |
| s. as possible | |
| to Continue as much as possible | |
| Continue as much as can be agreed | |
| e agreed, need to get new te in plan, below) | |
| None (after completing and sending this form.) | |
| nclude as much of symptoe): | ms, |
| 1 | e in plan, below) None (after completing and sending this form.) Clude as much of symptom |

If patient has moved/will move, please give their new address & Tel, and GP name/address:

| | Date: | <u></u> | |
|---------------------------|-------|---------|--|
| Name of practitioner seei | - I | | |

Please remove the copy of this form and post it to the ELEVATE office, in Freepost envelope.

Please call UEA if there are any questions