

VenUS IV Compression Hosiery Trial

MONTHLY NURSE ASSESSMENT

Participant ID Number

Nurse Code - - e.g. SMI - 23 - 02
First three letters of SURNAME day of birth month of birth

Date / / 20
day month year

Is this participant still alive?

Yes

No Date of death / / 20*

Has this participant had a recurrence of a venous leg ulcer on their reference leg?

Yes Date of recurrence / / 20**

No

* = Please complete a Serious Adverse Event form and Participant Event Form (Section 3: Trial exit)

** = Please complete a Non-serious Adverse Event form

I confirm I am unable to supply the above information as I was unable to contact the participant, though having tried on three occasions.