ProFHER TRIAL: END OF ORTHOPAEDIC INPATIENT EPISODE FORM

Participant identification number: ☐☐☐☐

This form is for the **designated person** to complete when an eligible patient comes to the end of their inpatient episode in the Orthopaedic Department.

Date of admission: ☐☐ / ☐☐ / ☐☐☐☐ (*Day / Month / Year*)

Date of discharge: ☐☐ / ☐☐ / ☐☐☐☐ (*Day / Month / Year*)

Date of death *(if applicable)* ☐☐ / ☐☐ / ☐☐☐☐ (*Day / Month / Year*)

If the patient has **died**, please complete an **adverse event form** and return to York Trials Unit.

Discharged to: *(please cross one box)*

Home ☐ **Another Hospital** ☐ **Nursing Home** ☐ **Other** e.g. ward ☐

If **Other**, please give details: ☐

Surgical and other shoulder fracture complications prior to discharge:

Please cross in box(es) if recorded

Surgical site infection requiring treatment with antibiotics	☐	**Identified organism:**	☐
Haematoma formation at surgical site	☐	**Describe:**	☐
Nerve injury	☐	**Describe:**	☐
Implant related complication	☐	**Describe:**	☐
Dislocation/instability	☐	**Describe:**	☐
Other	☐	**Describe:**	☐

Please continue to complete the rest of this form overleaf.

Medical complications prior to discharge:

Please cross in box(es) if recorded

Confirmed myocardial infarction ☐ **Confirmed stroke** ☐

Chest infection ☐ **Other hospital acquired infection** ☐

If **Other hospital acquired infection**, *please describe:*

Deep vein thrombosis requiring treatment ☐ **Pulmonary embolism requiring treatment** ☐

Admission to intensive care unit ☐ **Number of days admitted to intensive care unit:** ☐☐

Admission to high dependency unit ☐ **Number of days admitted to high dependency unit:** ☐☐

Other serious event ☐

If **'Other serious event'**, *please describe:*

Other treatments (after patient's initial treatment):

Secondary surgery to shoulder

Yes ☐ No ☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐ *Day / Month / Year*

If 'Yes', please describe surgery in the box below:

Increased/new therapy for shoulder related complications (e.g. infection)

Yes ☐ No ☐ **Date started:** ☐☐ / ☐☐ / ☐☐☐☐ *Day / Month / Year*

If 'Yes', please describe treatment in the box below:

Treatment for serious newly diagnosed medical complication

Yes ☐ No ☐ **Date started:** ☐☐ / ☐☐ / ☐☐☐☐ *Day / Month / Year*

If 'Yes', please describe treatment in the box below:

Thank you for completing this form.