ProFHER TRIAL: ONE YEAR FOLLOW-UP FORM

Participant identification number: ☐☐☐☐

This form is for the **designated person** to complete for an eligible patient one year after they were enrolled into the trial.

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

Pre-Discharge:

Has the patient seen an occupational therapist? *(Please cross one box)*

Yes ☐ No ☐

Date of orthopaedic discharge: ☐☐ / ☐☐ / ☐☐☐☐
(i.e. end of orthopaedic treatment) Day Month Year

Discharged to: *(e.g. GP)*
(Please record details)

Complications that occurred after the initial treatment and, if applicable, after inpatient episode:

Please cross in box(es) if recorded

Complication		
Surgical site infection requiring antibiotics/further surgery	☐	**Describe:**
Avascular necrosis of humeral head	☐	**Describe:**
Implant failure	☐	**Describe:**
Dislocation/instability	☐	**Describe:**
Metalwork problems requiring further surgery	☐	**Describe:**
Non-union/Malunion requiring further treatment	☐	**Describe:**
Other	☐	**Describe:**

Other treatments after initial treatment and, if applicable, after inpatient episode:

Surgery to shoulder *(please cross one box)* Yes ☐ No ☐ **Date:** ☐☐ / ☐☐ / ☐☐☐☐
Day Month Year

If **'Yes'** describe surgery below.

Number of days as hospital in-patient ☐☐

Please continue to complete the rest of this form overleaf.

Increased/new therapy for shoulder related complication (e.g. infection)
(please cross one box)

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

If **'Yes'** describe treatment below.

Number of days as hospital in-patient ☐☐

Treatment for serious newly diagnosed medical complication
(please cross one box)

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

If **'Yes'** describe treatment below.

Number of days as hospital in-patient ☐☐

Post-Discharge (i.e. end of orthopaedic treatment):

Has the patient visited the orthopaedic/fracture clinic since discharge from orthopaedic treatment?
(please cross one box)

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

Number of visits ☐☐

If **'Yes'** please describe the reason(s) for attendance in the box below:

Has the patient been admitted to hospital for another fracture?
(please cross one box)

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

Number of days as hospital in-patient ☐☐

If **'Yes'** please provide details in the box below:

Thank you for completing this form.

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