ProFHER TRIAL: TWO YEAR FOLLOW-UP FORM

Participant identification number: ☐☐☐☐

This form is for the **designated person** to complete for an eligible patient between year one and two of being enrolled into the trial.

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

<u>For patients who were not discharged within one year of their original shoulder injury, please record date of orthopaedic discharge:</u>

Date of orthopaedic discharge:
(i.e. end of orthopaedic treatment)

☐☐ / ☐☐ / ☐☐☐☐
Day *Month* *Year*

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

<u>Complications that happened after one year:</u>

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:**

<u>Other treatments that happened after one year:</u>

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 the form overleaf.

Increased/new therapy for shoulder related complication 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 ☐☐

<u>Other patient admissions after one year:</u>

Has the patient visited the orthopaedic/fracture clinic this year?
(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 a fracture this year?
(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.