

### **Emergency CRF: RU Enrolment**

□Yes □No

□Yes □No

□No

Centre No.:	Centre Name:		
Patient Trial ID No.:	Patient Date of Birth:	Patient Initials:	Date of Assessment:

#### **Resource Utilisation (RU)**

Was the patient admitted to an intensive therapy unit (ITU) at any time after the date of the first	
positive blood culture?	

If yes, give date of admission to ITU:

lf y	ves	has	the	patient	been	discharged	from	ITU?	

If yes.	give date of disch	arge from ITU:	1 1

Was the patient admitted to a high dependency unit (HDU) at any time after the date of the first	
positive blood culture?	

If yes, give date of admission to HDU:

If yes, has the patient been discharged from HDU?

If yes, give date of discharge from HDU: \_\_\_/\_/

Investigations

Were any investigations performed on this patient whilst being treated for this episode	□Yes
of S. aureus bacteraemia?	Lites

Ultrasound scan (other than echocardiogram)	Performedtime	s
CT Scan	Performedtime	s
☐ MRI Scan	Performedtime	s
PET Scan	Performedtime	s
PET CT Scan	Performedtime	s
Bone Scan	Performedtime	s
☐ White cell scan	Performedtime	s
Other (please specify):	Performedtime	s

# Were any procedures performed on this patient whilst being treated for this episode of $\Box$ Yes $\Box$ No *S. aureus* bacteraemia?

Radiologically guided biopsy/aspriate/abcess drainage	Performed	_times
☐ Surgical drainage/removal of non-device related focus requiring general or spinal anaesthesia	Performed	_times
Surgical removal of infected prosthetic device requiring general or spinal anaesthesia	Performed	_times
Cardiac surgery for <i>S. aureus</i> endocarditis	Performed	_times
Other procedure		
Please specify:	Performed	times

Completed by: (Print name)	Signature:	Date: (dd/mm/yyyy)



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Please return completed CRF to the ARREST Team within 48 hours of completion by fax to

# ARREST

### **Emergency CRF: RU Follow-up**

Centre No.:	Centre Name:				
Patient Trial ID No.:	Patient Date of Birth:	Patient Hospital No.:		Date of Assessment:	
		ł		L	
Resource Utilisation (R	0)				
Was the patient admitted t visit?	o an intensive therapy uni	t (ITU) at any time s	since the last s	study □Yes □No	
If yes, give date of	of admission to ITU:	//			
<b>If yes</b> , has the pa	tient been discharged fror	n ITU?		□Yes □No	
<b>If yes</b> , give date	of discharge from ITU:	//			
Was the patient discharge	d from a previously reporte	ed admission to ITU	J?	□Yes □No	
<b>If yes</b> , give date	of discharge from ITU:	//			
Was the patient admitted t visit?	o a high dependency unit	(HDU) at any time :	since the last s	study □Yes □No	
If yes, give date:	//				
<b>If yes</b> , has the pa	tient been discharged fror	n HDU?		□Yes □No	
If yes, give date:	//				
Was the patient discharge	d from a previously reporte	ed admission to HD	U?	□Yes □No	
If yes, give date:	//				
Investigations					
Have any new investigation			treated for thi	s □Yes □No	
episode of <i>S. aureus</i> bacter		study visit)?	Performed		
CT Scan			_	times	
MRI Scan			Performed		
			Performed		
PET CT Scan			Performed		
Bone Scan			-		
—			Performed _		
White cell scan			Performed _		
Other (please specify): _		· · · · · · · · · · · · · · · · · · ·	Performed _	times	
Have any new procedures been performed on this patient whilst being treated for this episode of <i>S. aureus</i> bacteraemia (i.e. since the last study visit)?					
Radiologically guided biopsy/aspriate/abcess       Performed times         drainage       Performed times				nes	
Surgical drainage/removal of non-device related focus requiring general or spinal anaesthesia					
Surgical removal of infected prosthetic device Performedtimes requiring general or spinal anaesthesia				nes	
Cardiac surgery for S. au	reus endocarditis	Performed	tim	ies	
Other procedure – please	procedure – please describe: Performedtimes				



# Emergency CRF: RU Follow-up

Centre No.:	Centre Name:		
Patient Trial ID No.:	Patient Date of Birth:	Patient Hospital No.:	Date of Assessment:
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Completed by: (Print name)	Signature:	Date: (dd/mm/yyyy)
Poturn completed CPE to the APPE	CT Toom within <b>49 hours</b> of completion by fax to	Î.

Return completed CRF to the ARREST Team within 48 hours of completion by fax to

# ARREST

# Emergency CRF: RU Follow-up

Centre No.:	Centre Name:	Centre Name:						
Patient Trial ID No.:	Patient Date of Birth:	Birth: Patient Hospital No.: Date of Assessment:						
Passures I Itilisation	(PII) (nrint more parce i	f required)						
Resource Utilisation (RU) (print more pages if required)         After discharge from hospital, has the patient been seen by their GP?         Yes								
If yes, how many GP visits were related to <i>S. aureus</i> infection or side effects of infection treatment?								
If yes, how many GP visits were unrelated to infection?								
After discharge from hospital, has the patient been seen in any other hospital out-patient clinic?								
<b>If yes</b> , how many visits to an out-patient clinic were related to <i>S. aureus</i> infection or side effects of infection treatment?								
If yes, how many visits to an out-patient clinic were unrelated to infection?								
After discharge from hospital following treatment for the bacteraemia, has the patient been admitted to hospital?								
If yes, record below the hospital admissions without staying overnight:								
Reason for admission Procedures undertaken (mark one)								
related to the infection side effects of the infecti	on treatment		//RI scan ☐PET scan					
Duprelated to infection		ne scan 🛛 🗌 Echocardiog	gram 🗌 Day-surgery					

unrelated to infection	Bone scan Echocardiogram	Day-surgery
related to the infection or related to the side effects of the infection treatment	None CT scan MRI scan	□PET scan
Unrelated to infection	Bone scan Echocardiogram	Day-surgery
related to the infection or related to the side effects of the infection treatment	None CT scan MRI scan	PET scan
□unrelated to infection	Bone scan Echocardiogram	Day-surgery

If yes, record below the hospital admissions as an inpatient:

Reason for admission	No. nights i hospita	•	No. nights in HDU	Procedures undertaken (mark one)	
related to the infection or related to the side effects				□None □CT scan □MRI scan □PET scan □Bone scan □Echocardiogram	
of the infection treatment					
unrelated to infection				Surgery requiring general or spinal anaesthesia	
				Other, please describe:	
related to the infection or				□None □CT scan □MRI scan □PET scan	
related to the side effects of the infection treatment				☐Bone scan ☐Echocardiogram	
	Surgery requiring general or		Surgery requiring general or spinal anaesthesia		
unrelated to infection				Other, please describe:	
related to the infection or				□None □CT scan □MRI scan □PET scan	
related to the side effects of the infection treatment				Bone scan Echocardiogram	
☐unrelated to infection				☐Surgery requiring general or spinal anaesthesia	
				Other, please describe:	
Completed by: (Print name)		Signature:	•	Date: (dd/mm/yyyy)	



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Patient Trial ID No.:	Patient Date of Birth:	Patient Hospital No.:	Date of Assessment:			
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