Evaluation of HIS-UK Study
Self-Referral Case Report Form (SR-CRF)

Site ID C A M - 0 0 5 **Study Participant ID** | | | | | |

1. Pre-consultation data transfer checklist

Chlamydia screening: ☐ Single ☐ Triple

Trial group: ☐ Usual care (control) ☐ proHIS ☐ eHIS

Digital recording: ☐ Required ☐ Not required

2. Consultation bookings

Date	Method (online / in-clinic)	Consultation Outcome (completed / partial completion / not completed)

3. Consent

Date: _____/_____/_____

Name of person re-confirming consent:_____

Study documents were thoroughly reviewed by the subject ☐ Yes ☐ No

Subject understands the nature of the study and what is involved ☐ Yes ☐ No

Subject is able to give informed consent ☐ Yes ☐ No

Comments:

4. Patient registration

Patient Record ID | | | | | | | | | |

6. Samples collected

Urine:

☐ Yes ☐ Subject refused ☐ Not required ☐ Postal-kit requested ☐ Postal-kit provided

Anal swab:

☐ Yes ☐ Subject refused ☐ Not required ☐ Postal-kit requested ☐ Postal-kit provided

Oral swab:

☐ Yes ☐ Subject refused ☐ Not required ☐ Postal-kit requested ☐ Postal-kit provided

6. Intervention delivery

Trial group: ☐ Usual care (control) ☐ proHIS ☐ eHIS

Digital recording: ☐ Yes ☐ No ☐ Not required

7. Protocol Deviation

Comments /reasons:

Site PI Signature: _____ Date: _____

This form should be completed for each participant screened

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Chlamydia screening

Date of screening / kit sent	Method (Postal/in-clinic)	Test Type (Single/Triple)	Date of results transfer to study team
14/05/19	*Postal*	*Single*	*28/05/19*
20/05/19	*In-clinic*	*Triple*	*31/05/19*

Comments:

Site PI Signature: _____ Date: _____