

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

Site ID

D	O	R
---	---	---

 -

0	0	2
---	---	---

Study Participant ID

2	0			
---	---	--	--	--

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

Self-Referral Case Report Form (SR-CRF)

Site ID

D	O	R	-	0	0	2
---	---	---	---	---	---	---

Study Participant ID

2	0			
---	---	--	--	--

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: _____