Serious Medical Event Log

ID. No.: __ __ - __ __ __   Alpha Code: __ __ __ __

Instructions: Record all hospitalizations & other major medical events that occurred since the end of the CATT study. Use additional page(s) if needed.
Record the name of hospital (if applicable), physician contact and any other pertinent information corresponding to each event on the following pages.

MedDRA Code	MedDRA Name	Event Type	Outcome	If Ocular Event, Check Eye(s) R L	Start Date (Month / Day / Year)	Stop Date (Month / Day / Year)
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __
				☐ ☐	__ __ / __ __ / __ __	__ __ / __ __ / __ __

Event Type	Outcome	Start and Stop Dates
1 = Hospitalization 2 = Other medically significant event	1 = Not Recovered 2 = Recovered 3 = Resolved with Sequelae 4 = Recovering/ Resolving)	Enter best estimate of start/stop dates. If any part of the dates are unknown for the Month, Day or Year, enter 99 for each unknown value.

Completed by: _____ Certification #: __ __ __ __ Date Completed: __ __ / __ __ / 201 __

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Please collect the information below for each medical event listed on page 1 and retain in the subject's file in case additional information regarding the events is required. **This page is not for data entry**.

Event Name	Name of Hospital (if applicable)	Physician	Physician Address /Phone	Additional Notes

Completed by: _____ Certification #: __ __ __ __ Date Completed: __ __ / __ __ / 201 __

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Event Name	Name of Hospital (if applicable)	Physician	Physician Address /Phone	Additional Notes

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Event Name	Name of Hospital (if applicable)	Physician	Physician Address /Phone	Additional Notes

Completed by: _____ Certification #: __ __ __ __   Date Completed: __ __ / __ __ / 201 __