

PROMOTE II BIRTH COHORT 3: SUBJECT DEATH CASE RECORD FORM

Study ID B 3 -- -- Patient Initials: Date form completed: / /
Last First day month year

Subject Death Form	
Date of Death: <u> </u> <u> </u> / <u> </u> <u> </u> / <u> </u> <u> </u> day month year	
Cause(s) of death (List up to 3 diagnoses with appropriate codes) 1 st Diagnosis: _____ Dx code: _____ 2 nd Diagnosis: _____ Dx code: _____ 3 rd Diagnosis: _____ Dx code: _____	
How was the cause(s) of death ascertained (tick all that apply)? <input type="checkbox"/> Autopsy report <input type="checkbox"/> Hospital records <input type="checkbox"/> Contact report: Explain _____ <input type="checkbox"/> Other: _____	
Was the subject's death related to malaria (tick one)? <input type="checkbox"/> Definitely <input type="checkbox"/> Probably <input type="checkbox"/> Possibly <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Where did the subject die (tick one)? <input type="checkbox"/> Home <input type="checkbox"/> Health Center <input type="checkbox"/> Private Clinic <input type="checkbox"/> Hospital <input type="checkbox"/> Unknown <input type="checkbox"/> Other location: _____	
If the subject was hospitalized fill out Hospital Admission CRF Always fill out a Subject Withdrawal or Study Completion CRF Completed by ____ (Initials)	