Case ID #:_____

Manufacturer Date of Receipt: _____

Reporter information						
Reporter Name:		Reporter address:		Telephone # Fax #:	# :	
Patient details					T	
Initials:	Sex: □	Male	Weight:	lb □ kg	Height:	☐ in ☐ cm
Date of Birth (DD/MM/YY) or Ag	e:		Ethnic Origin:		Race:	
Adverse event details						
Adverse Event(s)		Start Date (DD/MM/YY)	End Date (DD/MM/YY)		Outcome	
				☐ Ever	nt ongoing 🔲 F	Recovered
				☐ Reco	overed with sec	uele 🗌 Patient Died
1.Please describe the maligna	ancy:		1	l.		
- Anatomical location:	-					
- Histological type:						
- TNM classification:						
- Grade:						
- Hormone receptor status- Es	strogen:_					
-Pr	ogestero	ne:				
-H€	er2/neu:_					
- Second/Secondary:						

□ Navedia au = = !=	new diagnos	is (acute event) or a	relapse/di	isease p	rogression of a p	reexisting condition	on?		
☐ New diagnosis ☐ Relapse/Disease progression.									
What was the prior disease?									
	What was the prior onset date?								
3. Was there a pre	cipitating fact	or for exacerbation?							
□ No □ UNI	. •	s, Please specify:							
		.,					=		
4. Please provide	orior screenin	g test results with dat	tes if appr	opriate (e.g. mammogran	ı):			
		J	• • •	. `		,			
5. Please provide t	the method of	diagnosis and test re	esult(s). C	hoose a	ll that apply.				
☐ CT/MRI/Ultrasc	und. Result c	f:							
☐ Genetic testing	. Result of:								
☐ CD marker eva	luation. Resu	t of:							
Other, specify:									
Dapagliflozin therapy									
Indication:		Daily dosage:		Start da	ite (DD/MM/YY):	Stop date (L	DD/MM/YY):		
							DD/MM/YY):		
	topped due to	Daily dosage: the event(s)? Yes,	permanent				DD/MM/YY):		
Was dapagliflozin s				tly 🗌 Ye	es, temporarily	No N/A	DD/MM/YY):		
Was dapagliflozin s Was dapagliflozin ro Does the reporter co	e-introduced?	the event(s)? Yes,	uced:	tly 🗌 Ye	es, temporarily No N/	No N/A	DD/MM/YY):		
Was dapagliflozin s	e-introduced?	the event(s)? Yes,	uced:	tly 🗌 Ye	es, temporarily No N/	No N/A	DD/MM/YY):		
Was dapagliflozin s Was dapagliflozin ro Does the reporter co	e-introduced?	the event(s)? Yes,	uced:	tly 🗌 Ye	es, temporarily No N/	No N/A	DD/MM/YY):		
Was dapagliflozin re Was dapagliflozin re Does the reporter co Yes No Pl	e-introduced? onsider there lease explain:	the event(s)? Yes,	uced:	tly 🗌 Ye	es, temporarily No N/	No N/A	DD/MM/YY):		
Was dapagliflozin s Was dapagliflozin re Does the reporter c ☐ Yes ☐ No Pl	e-introduced? onsider there lease explain:	the event(s)? Yes,	uced:	tly 🗌 Ye	es, temporarily No N/	No N/A			
Was dapagliflozin re Was dapagliflozin re Does the reporter co Yes No Pl	e-introduced? onsider there lease explain:	the event(s)? Yes, Yes, date re-introdute be a causal relations	uced:	tly ☐ Ye	es, temporarily No N/A	No N/A dverse event(s)? Stop Date	DD/MM/YY): Was this also a suspect		
Was dapagliflozin s Was dapagliflozin re Does the reporter c ☐ Yes ☐ No Pl Concomitant med Exclude drugs to treat	e-introduced? onsider there lease explain: dications at the event(s)	the event(s)? Yes, Yes, date re-introdute be a causal relations	uced:ship between	tly ☐ Ye	es, temporarily No N/A Igliflozin and the a	No □ N/A A dverse event(s)?	Was this also a suspect medication?		
Was dapagliflozin re Does the reporter company of the Pl Concomitant medicated by the Pl Concomitant medicated by the Pl Exclude drugs to treated by the Pl	e-introduced? onsider there lease explain: dications at the event(s)	the event(s)? Yes, Yes, date re-introdute be a causal relations	uced:ship between	tly ☐ Ye	es, temporarily No N/A	No N/A dverse event(s)? Stop Date	Was this also a suspect medication? ☐ Yes ☐ No		
Was dapagliflozin re Does the reporter company of the Pl Concomitant media Exclude drugs to treat	e-introduced? onsider there lease explain: dications at the event(s)	the event(s)? Yes, Yes, date re-introdute be a causal relations	uced:ship between	tly ☐ Ye	es, temporarily No N/A	No N/A dverse event(s)? Stop Date	Was this also a suspect medication?		

Relevant medical history/concurrent diseases and risk	factors, Please provide details if available			
- Alcohol>2drinks/day:	- Family history of breast cancer (1st degree relative w/BC): Yes No UNK - BRCA-1 or BRCA-2 mutation: Yes No UNK - Lobular carcinoma in situ: Yes No UNK - Increased breast density (mammogram): Yes No UNK - Lack of physical activity: Yes No UNK - High fat diet: Yes No UNK			
- Past personal history of breast cancer/benign breast	- Other gene changes (ATM, p53, CHEK2, PTEN, CDH1):			
disease (e.g fibroadenoma) or ovarian cancer:	Yes □No □UNK			
│	Other; please specify:			
	Canon, produce opeouty.			
Please provide corrective treatment with dates of admir	sistration of treatment:			
☐ No corrective treatment administered				
Surgery: Specify type of surgery:	Date of surgery/(DDMMYY)			
☐ Medical treatment: Specify type of medical treatment:				
	Date of treatment/(DDMMYY)			
Radiotherapy: Date of radiotherapy//	DDMMYY)			
Date and Signature				
Date and dignature				
Date:				
Signature (Reporting Physician):				
Contact information				
Contact information	ompleted form to:			
Flease return c	ompeted form to.			
E-mail:				
Mail: Thank you for comp	leting this form.			

Case ID #:____

Manufacturer Date of Receipt: _____

Reporter information						
Reporter Name:	Reporter addres	Reporter address:		Telephone #: Fax #:		
Patient details		1				
Initials:	Sex: Male Female	Weight:	lb □ kg	Height:	☐ in ☐ cm	
Date of Birth (DD/MM/YY) or Age) :	Ethnic Origin:		Race:		
Adverse event details			<u> </u>			
Adverse Event(s)	Start Date (DD/MM/YY)	End Date (DD/MM/YY) Outcome			ome	
			☐ Even	t ongoing 🔲 F	Recovered	
			☐ Reco	vered with seq	uele Patient Died	
1.Please describe the malignancy:						
- Anatomical location on bladder (e	e.g. neck, fundus, body):					
- Growth pattern (e.g. papillary, non-papillary, metastatic, isolated):						
- Histological type (e.g. transitional, squamous, adeno):						
- TNM classification (e.g. pT1, pN2	2, M0):					
- Grade/Stages (e.g. high-grade, low-grade or other):						

Case ID #:_____

Manufacturer Date of Receipt: _____

2. Was the event a new diagnosis (acute event) or a relapse/disease progression of a preexisting condition? New diagnosis Relapse/Disease progression. What was the prior disease?
What was the prior onset date?
3. Does the subject have a history of hematuria (micro and/or macro)?
□ No □ UNK □ Yes, (If Yes, please complete information below)
Start date:/ (DDMMYY)
Other occasion dates:
Known cause of the hematuria:
4. Does the subject have urinary symptoms (or other symptoms)?
No ☐ UNK ☐ Yes, dysuria, start date of/(DDMMYY)
☐ Yes, urgency, start date of/(DDMMYY) ☐ Yes, polyuria, start date of/(DDMMYY)
Yes, increased frequency, start date of/(DDMMYY)
Yes, other:
Specify:, start date of/(DDMMYY)
5. What prompted the investigations that led to diagnosis?
☐ Urinary or other symptoms, please specify:
☐ Hematuria, please specify if gross or microscopic hematuria:
☐ Other, please specify:
6. Please provide the method of diagnosis and test result(s). Choose all that apply. You may provide copies of any test results.
Cystoscopy. Result of:
Histopathology. Result of:
Cytology. Results of:
☐ Imaging (e.g. CT scan, MRI, ultrasound) Result of:
Other, specify:

Dapagliflozin therapy

Case ID #:____

		Manufacturer Da	ate of R	eceipt: _			
Indication:	Daily dosage: Start date (DD/MM/YY): Stop date (DD/MM/YY):						DD/MM/YY):
Was dapagliflozin stopped due to the event(s)? ☐ Yes, permanently ☐ Yes, temporarily ☐ No ☐ N/A							
Was dapagliflozin re	e-introduced?] Yes, date re-introdu	uced:			4	
Does the reporter co		e a causal relations	ship betw	veen dapa	agliflozin and the a	adverse event(s)?	
Concomitant med							
Exclude drugs to trea	Indication	Daily Dosage	Ro	ute	Start Date (DD/MM/YY)	Stop Date (DD/MM/YY)	Was this also a suspect medication?
							☐ Yes ☐ No
							Yes No
							☐ Yes ☐ No
							☐ Yes ☐ No
□ No □ UNK Number of pack Number of years b. Has the pa	atient smoke? Yes (If Yes, s/day: been smoking: tient ever smoked Yes (If Yes,	please complete inf	formation	below)			
Number of years	been smoking:			Sto	pped smoking:	(Year)
c. Does the s	ubject have any of	the following risk fac	ctors? Che	eck all tha	t apply		
i. E	exposure to arseni	c, aromatic amines (e.g. anilin	e), phenad	cetin, Chinese herb	s (e.g. aristolochic	acid) and
C	hemicals used in t	he manufacture of d	yes, rubb	er, leather	, textiles and paint p	products, cyclophos	sphamide
[□ No □ UNK □ `	Yes (If Yes, please c	omplete i	nformation	n below)		
C	Compound:		E	kposure (d	lose and time):		
ii. F	las the subject eve	er used products or o	combination	on product	s containing pioglita	azone?	

Case ID #:_____

	Manufacturer Date of Receipt:
	□ No □ UNK □ Yes
	If Yes, specify dates:
iii.	Chronic cystitis
	□ No □ UNK □ Yes
iv.	Indwelling urinary catheter
	□ No □ UNK □ Yes
٧.	Radiation exposure
	□ No □ UNK □ Yes
vi.	Past personal history of bladder cancer or benign bladder neoplasms
	□ No □ UNK □ Yes
vii.	Family history of bladder cancer
	□ No □ UNK □ Yes
viii.	Family history of hereditary nonpolyposis colorectal cancer (HNPCC) or Lynch syndrome
	□ No □ UNK □ Yes
ix.	Other, specify:
se provid	e corrective treatment with dates of administration of treatment:
	treatment administered
	cify type of surgery: Date of surgery/(DDMMYY)
edical treatr	ment: Specify type of medical treatment: Date of treatment/(DDMMYY)
	Date of treatment / / / (DDMMYY)

Date and Signature		
_ acc ama criginature		

Case ID #:_____

Manufacturer Date of Receipt: _____

	'	
Date:		
Signature (Reporting Physician):		-
Contact information		
	Please return completed form to:	
Fax:		
E-mail:		
Maile		
Mail:		
	Thank you for completing this form.	

Reporter information					
Reporter Name:	Reporter address		elephone # ax #:	! :	
	1				
Patient details					
Initials:	Sex: Male Female	Weight: lb	kg	Height:	☐ in ☐ cm
Date of Birth (DD/MM/YY) or Ag	e:	Ethnic Origin:		Race:	
Adverse event details					
Adverse Event(s)	Start Date (DD/MM/YY)	End Date (DD/MM/YY)		Outc	
				t ongoing 🔲 Rovered with sec	Recovered quele
1.Please describe the malignan	су:				
- Histological type:				····	
-TNM classification (e.g. pT1, pN2	2, M0):		 		
- Grade (Gleason score if available (Please indicate type of grading s					
- Stage:			······································		
_					
2. Has the cancer metastasi	zed (specify secondary loca	tion(s))?			_
☐ Still confined to the prostate	e				
3. Is this a:					
☐ New diagnosis (acute event) or				
☐Relapse/Disease progressio	n. What was the prior disease	?			
	What was the prior onset da	ate?			
4. Did the subject have prior ele	evation of PSA?		 		
Highest value of PSA on study	drug:	on:/	_/	(DDMMYY)	
PSA value prior to beginning of	study drug:	on:/	/	(DDMMYY)	

5. Please provide prior screening	results with dates of tests (e.g.	Digital Rectal Exam):_			

6. What prompted the investigation ☐ Routine screening	ons that led to diagnosis?				
☐ High PSA values					
☐ Other, please specify:					
7. Specify any history of sympton	ns preceding the diagnosis and	l dates (if known)			
☐ Hematuria (micro and/or macro):	on: _	/	/	_ (DDMMYY)
☐ Hematospermia:		on: _		/	_ (DDMMYY)
☐ Other urinary symptoms (e.g. d	ysuria, urgency, polyuria, pollakiu	ıria:			
		on: _	/	_/	(DDMMYY)
Persistent pain in the back, hips	s or pelvis:	on: _	/	/	_ (DDMMYY)
Painful ejaculation:		on: _		/	_ (DDMMYY)
8. Please provide the method of d	liagnosis and test result(s). Cho	oose all that apply. You	may prov	vide copi	es of any test results.
☐ Histopathology. Result of:					
Cytology. Results of:	·····				
☐ Imaging (e.g. CT scan, MRI, ultra	asound) Result of:				
Other, specify:					
Dapagliflozin therapy					
Indication:	Daily dosage:	Start date (DD/MM/Y)	Y):	Stop da	ate (DD/MM/YY):
Was dapagliflozin stopped due to	the event(s)? Yes, permane	ntly ☐ Yes, temporarily	☐ No	□ N/A	
Was dapagliflozin re-introduced?	Yes, date re-introduced:		N/A		
Does the reporter consider there ☐ Yes ☐ No Please explain:	to be a causal relationship betv	veen dapagliflozin and	the adver	se event	(s)?

Case ID #:	
Manufacturer Date of Receipt:	

Concomitant medications Exclude drugs to treat the event(s)										
Drug Name	Indication	Daily Dosage	Route	Start Date (DD/MM/YY)	Stop Date (DD/MM/YY)	Was this also a suspect medication?				
						☐ Yes ☐ No				
						☐ Yes ☐ No				
						☐ Yes ☐ No				
						☐ Yes ☐ No				
						☐ Yes ☐ No				

Rele	van	nt medica	al history/concurrent diseases and risk factors		
	a.	Does the	e patient smoke?		
	□ N	No □UI	NK Yes (If Yes, please complete information below)		
	Nun	nber of pa	cks/day:		
	Nun	nber of yea	ars been smoking:		
	b.	Has the	patient ever smoked previously?		
	□ N	No □UI	NK Yes (If Yes, please complete information below)		
	Nun	nber of pa	cks/day:		
	Nun	nber of yea	ars been smoking:s	Stopped smoking:	_ (Year)
	c.	Does the	subject have any of the following risk factors? Check all t	that apply	
		i.	Exposure to heavy metals (e.g. cadmium)		
			☐ No ☐ UNK ☐ Yes (If Yes, please complete informat	tion below)	
			Compound: Exposure	e (dose and time):	
		ii.	Exposure to agent orange or chlorderone?		
			□ No □ UNK □ Yes		
			If Yes, specify dates:		
		iii.	Prior androgen use?		
			□ No □ UNK □ Yes		
		iv.	High dietary fat intake?		
			□ No □ UNK □ Yes		
		v.	Lack of physical activity / inactivity?		
			□ No □ UNK □ Yes		
		vi.	Past personal history of prostate cancer or benign prosta	ate neoplasms?	

	□ No □ UNK □ Yes			
vii.	Past personal history of prostitis or trichomonas?			
	□ No □ UNK □ Yes			
viii.	Family history of prostate cancer?			
	☐ No ☐ UNK ☐ Yes (specify father, brother, son etc):			
ix.	Vasectomy?			
	□ No □ UNK □ Yes			
x.	BRCA 1 and / or 2 mutation?			
	□ No □ UNK □ Yes			
xi.	Heavy alcohol use (ethanol >50g per day, > ~5 alcoholic	drinks per day)?		
	□ No □ UNK □ Yes			
xii.	☐ Other, specify:			
•	de corrective treatment with dates of administration of t		/	 _ (DDMMYY)
☐ Surgery :	nent :	on: on:	/	 (DDMMYY)
☐ Surgery : ☐ Medical treatm ☐ Radiotherapy	nent :	on:on:		 (DDMMYY) (DDMMYY)
☐ Surgery : ☐ Medical treatm ☐ Radiotherapy	nent :	on:on:		 (DDMMYY) (DDMMYY)

Case ID #:____

Manufacturer Date of Necerpt.
Please provide corrective treatment with dates of administration of treatment:
□ No corrective treatment administered
☐ Surgery: Specify type of surgery: Date of surgery/(DDMMYY)
☐ Medical treatment: Specify type of medical treatment:
Date of treatment/ (DDMMYY)
Radiotherapy: Date of radiotherapy/(DDMMYY)
Date and Signature
Date:
Signature (Investigator or Reporting Physician):
Contact information
Please return completed form to:
Fax:
E-mail:
E-IIIaii.
A.A.:II.
Mail:
Thank you for completing this form.

Request for Additional Information in response to event or symptoms of diabetic ketoacidosis Case ID# Manufacturer Date of Receipt Reporter Information Reporter Name: Reporter address: Telephone #: Fax#: Email: Please note that information already provided in the original event report does not need to be repeated in this form! **Patient Details** Initials: Sex: Weight: Height: ☐ Male ☐ Female □ lb □ kg □ in □ cm Date of Birth (DD/MM/YY) or Age: **Ethnic Origin:** Race: Type of diabetes Other: T2DM □ Not applicable □ T1DM □ LADA □ Ketosis prone □ (non-diabetic) **Duration of diabetes** < 1 Year \square 1-3 Year □ 3-5 Year □ 5-10 Year □ >10 Year 🗖 **Adverse Event Details** Adverse Event(s) Stop Date Start Date Outcome (DD/MM/YY) (DD/MM/YY) Recovered ☐ Recovered with sequelae Event ongoing □ Patient died Recovered ☐ Recovered with sequelae Event ongoing □ Patient died Diagnostic criteria and clinical diagnosis of the event(s): Was the patient hospitalized for the event(s)? If 'Yes' to any of the questions to the left, please provide a brief statement of clinical course, relevant treatment and any complications from the event(s): □ Yes □ No Was treatment provided? ☐ Yes ☐ No

Start Date (DD/MM/YY):

☐ Yes, permanently
☐ Yes, temporarily

Stop Date (DD/MM/YY):

□ N/A

□ No

Daily dosage:

Dapagliflozin therapy

Was dapagliflozin stopped due to the event(s)?

Indication:

If yes, did the event(s) improv	ve after stopping dap	agliflozin?	_ v		□ V 4		. NI/A
Was dapagliflozin re-introduc				es, permanently			N/A
If yes, did the event(s) recur				es, permanently	· · ·	, i	N/A
Does the reporter consider th				es, permanently		(e)2	N/A
·		•				Yes	No No
Please explain:							
Antidiabetic medications	(include treatments	s up to 3 mo	nths in adv	ance of the r	eported even	t)	
Drug Name	Indication	Daily	Route	Start Date	Stop Date	Was this a susp	oct
Drug Name	marcation	Dosage	Route	(DD/MM/YY)	(DD/MM/YY)	medication?	
						□ Yes □ No	
						□ Yes □ No	
						□ Yes □ No	
						□ Yes □ No	
						□ Yes □ No	
						□ Yes □ No	
						□ Yes □ No	
Please comment on any known							
Other relevant concomita							
		Daily	Route	Start Date	Stop Date	Was this a susp	pect
Other relevant concomital Exclude drugs used to treat the	event	Daily Dosage	Route	Start Date (DD/MM/YY)	Stop Date (DD/MM/YY)	Was this a susp medication?	
Other relevant concomital Exclude drugs used to treat the	event		Route				
Other relevant concomital Exclude drugs used to treat the	event		Route			medication?	
Other relevant concomital Exclude drugs used to treat the	event		Route			medication? Yes	
Other relevant concomital Exclude drugs used to treat the	event		Route			medication?	
Other relevant concomital Exclude drugs used to treat the	event		Route			medication?	
Other relevant concomital Exclude drugs used to treat the	event		Route			medication? Yes	
Other relevant concomital Exclude drugs used to treat the	event		Route			medication? Yes	
Other relevant concomital Exclude drugs used to treat the Drug Name	Indication	Dosage		(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomita Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors	Indication Indication	Dosage Other Start	Date St	(DD/MM/YY)		medication? Yes	
Other relevant concomitations in the Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors Previous episodes of ketoacido	Indication	Dosage Other Start	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomita Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors	Indication	Other Start (DD/I	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomital Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors Previous episodes of ketoacide Carbohydrate reduced diet/Rec	ncurrent diseases or Disis	Other Start (DD/I	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomital Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors Previous episodes of ketoacido Carbohydrate reduced diet/Reccaloric intake	ncurrent diseases or Sis Yes Guced Yes Yes	Other Start (DD/II	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomita Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors Previous episodes of ketoacide Carbohydrate reduced diet/Reccaloric intake Surgery	ncurrent diseases or posis	other Start (DD/II) No No	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomita Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors Previous episodes of ketoacido Carbohydrate reduced diet/Reccaloric intake Surgery Infection	ncurrent diseases or Disis	Other Start (DD/) No No No	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomitation in Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors Previous episodes of ketoacido Carbohydrate reduced diet/Recaloric intake Surgery Infection Alcohol intake	ncurrent diseases or bis Yes Yes Yes Yes Yes Yes Yes Yes Yes	other Start (DD/IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	
Other relevant concomita Exclude drugs used to treat the Drug Name Relevant medical history, concontributing factors Previous episodes of ketoacide Carbohydrate reduced diet/Reccaloric intake Surgery Infection Alcohol intake Recent Cardiovascular Episode	ncurrent diseases or posis	Dosage	Date St	(DD/MM/YY)	(DD/MM/YY)	medication? Yes	

Relevant medical history, conce contributing factors	urrent discases Of	Julei	Start Date (DD/MM/YY)	Stop D (DD/MI	yes, pic	ease provide det	u110
Dehydration	☐ Yes	□ No					
Increased exercise	☐ Yes	□ No					
Other, please specify:	☐ Yes	□ No					
	□ Yes	□ No					
		□ No					
	1.00						
Laboratory Test	Peak Value	Unit	Sample (DD/MN		nce Values .to)	Follow-up value	Follow-up Da
lood/Plasma Glucose							
ood pH							
CO ₂							
erum Bicarbonate							
erum Potassium (K)							
erum Sodium (Na)							
ood/Serum Ketones							
ine Ketones							
Peptide							
etahydroxybutyrate							
GFR							
reatinine							
ther, please specify :							
iner, pieuse speerry .							
Date and Signature							
Date:	_						
Signature (Reporting Physician):					 		

Please return completed form to:								
Fax:								
E-mail:								
Mail:								

Thank you for completing this form.

Potential Liver Injury Questionnaire Request for Additional Information

Case ID #:									
Manufacturer Date of Receipt:									
Reporter information									
Reporter Name:		Reporter address:		Tel	lephone #	:			
				Fa	nx #:				
Patient details						ı			
Initials:	Sex: □	Male	Weight:	☐ lb [☐ kg	Height:	☐ in ☐ cm		
Date of Birth (DD/MM/YY) or Ag	e:		Ethnic Origin:			Race:			
Adverse event details									
Adverse Event(s)		Start Date (DD/MM/YY)	End Date (DD/MM/YY)			Outco	me		
						ngoing Recovered red with sequele			
						ngoing Recovered			
						ngoing Recovered			
Diagnostic criteria and clinical mental status changes etc, (b) I If a GI consult was obtained ple	Findings 1	rom physical exami	ination and (c) clin	ical d	iagnosis				
Was the patient hospitalized for ☐ Yes ☐ No ☐ UNK	the even	t(s)?							
Was treatment provided? if yes, please describe ☐ Yes ☐ No ☐ Unknown									
Were there any complications of if yes, please describe ☐ Yes	•	` '							

Potential Liver Injury Questionnaire Request for Additional Information

Dapagliflozin their	rapy							
Indication:		Daily dosage:		Start da	ate (DD/MM/YY):	Stop date (I	DD/MM/YY):	
Was dapagliflozin s	topped or the	dosage altered due to	the even	t(s)? 🗌 Y	es, permanently	Yes, temporarily	□ No □ N/A	
If yes, did the event(s) improve after stopping/altering dapagliflozin? ☐ Yes, date stopped or dose changed: ☐ No ☐ N/A								
Was dapagliflozin re-introduced?								
If yes, did the event(s) recur after reintroduction? Yes, date recurred: No NA								
Does the reporter compared to the Pl		o be a causal relations	ship betw	veen dapa	agliflozin and the a	dverse event(s)?		
Concomitant med Exclude drugs to treat								
Drug Name	Indication	Daily Dosage	Ro	ute	Start Date (DD/MM/YY)	Stop Date (DD/MM/YY)	Was this a suspect medication?	
							☐ Yes ☐ No	
							Yes No	
							☐ Yes ☐ No	
Relevant medical Please provide detail		urrent diseases dates of diagnosis and	resolution	ı if applica	ble			
- Hepato-biliary disea	ase (if yes, spec	ify): □Yes □No □UN	K	- Obesity: □Yes □No □UNK				
- Hyperlipidemia: 🔲	∕es □No □UN	K		- Alcoho	ol and/or drug abuse	e (if yes, specify):]Yes □No □UNK	
- Bleeding disorders	(if yes, specify):	☐ Yes ☐No ☐UNK		- Recer	nt vaccinations or tra	avels (if yes, specify	/):	
- Ischemic hepatitis (eg: hypotension	or CHF): Yes No	□UNK	□Yes [□No □UNK			
- Viral hepatitis A, B,	C or E (specify): □Yes □No □UNK			pational toxic agent/o		osure (if yes,	
- Cardiovascular dise	ease (if yes, spe	cify): □Yes □No □U	NK	specify)	:	ΝK		
		npromised status (if yes		- Releva	ant family history (if	yes, specify): ∐Y€	es	
specify): ☐Yes ☐No	o 🗌 UNK			- Neopla	asm (if yes, specify)	: ∐Yes ∏No ∏U	NK	
				Other (s	specify):			

Potential Liver Injury Questionnaire Request for Additional Information

Case ID #:	
Manufacturer Date of Receipt:	

(AST, ALT, (antigen/ant other testing	Total Bilirubir ibody/DNA), l g done at. a) b	n Alk-phospha histopathology paseline, b) at	atase), albumin, P y/biopsy, immune t time of the event nedication was co	PT, INR, bicarbonate, e-histochemistry (anti t, c) after interrupting ontinued, uninterrupte	eosinophils, ima inuclear antibody discontinuing s ed, subsequent t	pecial importance to liveraging studies, serology, antismooth muscle auspect medication, d) test results	y for viral hepatitis antibody etc) or any
Test	Reference (please prov (to	vide units)	Baseline Value (pre-treatment) ate (DD/MM/YY)/ Result	Event Onset Value Date (DD/MM/YY)/ Result		Post-withdrawal Test Value Date (DD/MM/YY)/ Result	Return to Normal Date (DD/MM/YY) Result
ALT							
AST							
Bilirubin							
ALP							
Other, please specify:							
Relevant imagin autopsy):	g studies (e.	g., abdomina	al ultrasound, C	Γ scan, MRI) and ot	her investigation	ons (e.g., drug scree	ning, biopsy,
Name of	Test	Test Date		Resu	ults (describe al	bnormality)	
		<u> </u>	☐ Normal ☐	Abnormal Describe:	;		
		<u>. </u>	☐ Normal ☐	Abnormal Describe:	: 		
Date and Si	anature						
D 410 1111	91.0.0						
Date:							
Signature (Rep	orting Physici	an):					
Contact info	ormation						
Contacting	7111100001		Please r	return completed fo	orm to:		
Fax:							
E-ma	il:						
Mail:							
			Thank v	ou for completing t	this form.		

Potential Renal Impairment/Failure Questionnaire Request for Additional Information

Reporter information						
Reporter Name:	Reporter add	•		Telephone #:		
			Fax #:			
			t			
Patient details						
	Carri 🗆 Mala 🖂 Farre	ala Majadati		71.0	I I a l'aulatu	□ in □ ana
Initials:	Sex: Male Fema	ale Weight:	☐ lb [_l kg	Height:	☐ in ☐ cm
Date of Birth (DD/MM/YY) or Ag	e:	Ethnic Orig	gin:		Race:	
, , ,			<u> </u>			
Adverse event details (for re	nal failure he specifi	ic about chronic	ity: acuto	chronic (or acuto on	chronic)
•	Start Date		Date	Cilionic		•
Adverse Event(s)	(DD/MM/YY)	-	IM/YY)		Outo	come
		<u> </u>	/	☐ Event on	going Recove	red
					ed with sequele	
				□ Event on	going Recover	red
					ed wth sequele	
					going ☐ Recover	
				_	ed with sequele	
Diagnostic criteria and clinical	liagnosis of the event(s	s) (brief description	n including			
status changes etc, (b) Finding						
If a nephrologist consult was of	otained please specify t	he findings or pro	vide the co	nsultation	report:	
Type of renal failure						
pre-renal renal (intrinsic)	☐ nost-renal ☐ Other(e	a acute alomerula	nenhritis int	eretitial ner	hritis tuhulai	necrosis)
	_ post-renai _ Other(e.	.g. acute giornerulo	mepinius, ini	ersuliai rie _l	Jilitis, tubulai	116010313)
Was the patient hospitalized for ☐ Yes ☐ No ☐ Unknown	tne event(s)?					
☐ Fes ☐ No ☐ Officiowit						
Was treatment provided? if yes	s, please describe					
☐ Yes ☐ No ☐ Unknown						
Were there any complications of	aused by the event(s)?	if yes, please des	scribe			
☐ Yes ☐ No ☐ Unknown						
Dapagliflozin therapy						
Indication:	Daily dosage:	Start	date (DD/MI	Л/YY) :	Stop dat	e (DD/MM/YY):
Was dapagliflozin stopped or th	ne dosage altered due to	o the event(s)? 🗌	Yes, perma	nently 🗌	Yes, tempora	irily 🗌 No 🔲 N/A
If yes, did the event(s) improve Yes, date stopped or dose cha		dapagliflozin? □ No □ N/A				

Potential Renal Impairment/Failure Questionnaire Request for Additional Information

Manufacturer Date of Receipt:								
Was dapagliflozin r	e-introduced?	Yes, date re-introdu	iced:	No N/	4			
If yes, did the event	t(s) recur after rein	troduction? Yes	s, date recurred: _] No □ N/A			
Does the reporter consider there to be a causal relationship between dapagliflozin and the adverse event(s)? ☐ Yes ☐ No Please explain:								
Concomitant medications Exclude drugs to treat the event(s)								
Drug Name	Indication	Daily Dosage	Route	Start Date (DD/MM/YY)	Stop Date (DD/MM/YY)	Was this also a suspect medication?		
						☐ Yes ☐ No		
						☐ Yes ☐ No		
	_L							
Relevant medical Please provide detai			esolution if application	able				
Hypertension:	s 🗆 No 🗆 UNK		SLE: □Yes	□No □UNK				
Diabetes mellitus:]Yes	(Rhabdomyol	Rhabdomyolysis:				
Heart failure: □Yes	□No □UNK		Sepsis/shock	Sepsis/shock: ☐Yes ☐No ☐UNK				
Drug abuse: □Yes	□No □UNK		Thrombosis:	Thrombosis: ☐Yes ☐No ☐UNK				
Exposure to contrast	t media: □Yes □N	No □UNK	Tumor lysis s	Tumor lysis syndrome: ☐Yes ☐No ☐UNK				
Obstruction of urinar	y tract: □Yes □N	o DUNK	Malignant dis	Malignant disease, if yes, specify: ☐Yes ☐No ☐UNK				
HIV/AIDS: □Yes □]No □UNK		Trauma: □Y	′es □No □UNK				
Organ transplantatio	n: ∐Yes ∐No □	UNK						
Hematological disord	der, if yes, specify: [⊒Yes □No □UN	K Liver disease	e, if yes, specify: \B\	′es ∐No ∐UNK			
			Other, specif	Other, specify:				

Potential Renal Impairment/Failure Questionnaire Request for Additional Information

Case ID #:	
Manufacturer Date of Receipt:	

(serum and un other testing of	rine creatini done at. a) l	ine, BUN, ure baseline, b) a	ea, GFR, cystatin C,	glucose/creatinir c) after interrupti	ne ratio, urianaly ng/discontinuing	special importance to ysis, urine volume, pr g suspect medication, nt test results	oteinuria, etc) or any
Test	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	rovide units) rovide units) (pre-treatment) Date (DD/MM/YY)/ Result Pasult Pasult Peak Value Date (DD/MM/YY)/ Result Pasult Post-withdrawal Test Value Date (DD/MM/YY)/ Result Pasult Post-withdrawal Test Value Date (DD/MM/YY)/ Result Pasult					
Serum creatinine							
BUN/Urea							
GFR							
Proteinuria							
Other, please specify :							
Relevant imaging autopsy):	studies (e	.g., abdomin	al ultrasound, CT s	scan, MRI) and	other investiga	itions (e.g., drug sci	reening, biopsy,
Name of T	est	Test Date		Res	sults (describe	abnormality)	_
			☐ Normal ☐ At	onormal, Describ	oe:		
			☐ Normal ☐ Al				
			☐ Normal ☐ At	onormal, Describ	oe:		
D (1 0'-	4						
Date and Sig	nature						
Date:							
Signature (Repor	ting Physici	an):					
Contact infor	mation						
			Please ret	urn completed	form to:		
Fax:							
E-mail:							
Mail:							

Thank you for completing this form.

Hypersensitivity Reaction, including Severe Cutaneous Adverse Reaction, Questionnaire Request for Additional Information

Reporter Information											
Reporter Name:		Reporter add	ddress:				Telephone #				
				Fax#							
L											
Patient Details											
Initials: Sex	C: Mala	□ Formula	W	eight:		_ n		Heig	ıht:		
				hnic Origir			□ kg	Race		□ in	□ cm
Date of Birth (BB/NNN/11) of Age.				illic Origii				Nace	J.		
								•			
Adverse Event Details											
Adverse Event(s)	Start Date	Stop Da					0	utcom	е		
	(DD/MM/YY)) (DD/MM/\)	YY)								
					Recover	ed			ecovered with s	equlae	
					Event or	ngoing	9	□ Pa	atient died		
					Recover	ed		□ Re	ecovered with s	equlae	
					Event or	ngoing	9	□ Pa	atient died		
				□ Recovered		ed		☐ Recovered with sequlae			
				□ Event ongoing		9	□ Patient died				
Diagnostic criteria and clin	Diagnostic criteria and clinical diagnosis of the event(s):										
Was the patient hospitalize	ed for the ev en	t(s)?	T	If 'Yes' to a	any of the	ques	tions to the	left, p	lease provide a	brief sta	tement of
☐ Yes ☐ No		. ,							complications f		
Was treatment provided?											
□ Yes □ No											
Was treatment provided?											
□ Yes □ No											
Did the patient experience	any of the follo	wing:			Start Da		Stop Da		Comments		
Anaphylactoid reaction, anap	ohylactic reaction	n/shock	Yes	s □ No	UDININ	<i></i> 1 1)	(DD/IVIIVI	, 1 1)			
Angioedema			Yes								
Respiratory reaction, including dyspnea, wheezing,			Yes								
bronchospasm, tongue swell swelling/obstruction	ing and/or throa	t 🗀									
Rash,urticaria with/without pruritis				s □ No							
Rash with eosinophilia and s	ystemic symptor	me	Yes								
Serious skin reaction, such a		tiforme,	Yes								
SJS, TEN, or exfoliative derr	natitis (please sp	pecify)	168	, LINU							
Other, please specify:			Yes	s □ No							

Dapagliflozin therapy								
Indication: Daily dosage:			Sta	rt Date (DD/N	MM/YY):	Stop Date (DD/MM/YY):		
Was dapagliflozin stopped due to the	ovent(e)?							
If yes, did the event(s) improve after s	• •	flozin?		es, permaner				
Was dapagliflozin re-introduced?	topping dapagii			'es, permaner		,		
If yes, did the event(s) recur after reint	troduction?			es, permaner	· '			
Does the reporter consider there to be		nshin hetwe		es, permaner	tho	, i		
adverse event(s)?	u oudour roluit	momp between	on dapa	9111102111 4114	☐ Yes	☐ No Please explain:		
Concomitant medications Exclude drugs used to treat the event								
	dication	Daily Dosage	Route	Start Dat		Was this a suspect medication?		
						□ Yes □ No		
						□ Yes □ No		
						□ Yes □ No		
						□ Yes □ No		
						□ Yes □ No		
						□ Yes □ No		
						□ Yes □ No		
Does the patient possess any of the fo	ollowing	Start Da		Stop Date DD/MM/YY)	If yes, please pr	ovide details		
History of allergies	□ Yes □ N	,	/ (
Family history of allergies	□ Yes □ N	No.						
Previous drug reactions	□ Yes □ N	No.						
Asthma or COPD	□ Yes □ N	No						
Significant cardiac disorders	□ Yes □ N	No.						
Autoimmune disease	□ Yes □ N	No.						
Immunocompromised status	□ Yes □ N	No.						
Recent vaccination	□ Yes □ N	No.						
Infection	□ Yes □ N	No.						
Other, please specify:	□ Yes □ N	No						
	□ Yes □ N							
Diagnostic Investigations (drug screen Name of Test	ning, biopsy, lat Was the te			Doculto (or	ecify abnormality	<u> </u>		
	performed			Results (sp	becity ability)		
Skin test or biopsy	□ No □ Y	'es		□ Normal	☐ Abnormal			
Drug provocation test	□ No □ Y	'es		□ Normal	☐ Abnormal			
Immunoglobulin tests (please specify):		′es		□ Normal	☐ Abnormal			
Other, please specify:	□ No □ Y	′es		□ Normal	□ Abnormal			

Specialist consultation		
Has a specialist been consulted?	- N	
	⊔ No	☐ Yes (If yes, please summarize or send a copy of the consultation report)
Disease manifest and for the constant in formation	4!	and the Advance France
Please provide any further relevant information include any other treatments received that have no	nation abo	Dut the Adverse Event
include any other treatments received that have hi	ot been pre	viously stated.
Date and Signature		
Date and Oignature		
Date:		
Signature (Reporting Physician):		
Contact Information		
P	lease ret	curn completed form to:
Fax:		
E-mail:		
Mail:		

Thank you for completing this form.

Case ID #:	
Manufacturer Date of Receipt:	

In diabetic patients, events such as gangrene, irreversibile infection, ulceration and peripheral vascular disease may lead to amputation. This is a request for information if the patient have had an amputation performed after initiation of dapagliflozin or dapagliflozin-metformin.

Reporter information								
Reporter Name:								
Reporter address:								
Telephone #:		Fax #:						
Patient details								
Initials:	Sex: Male Female	Weight: ☐ Ib ☐ kg	Height: in cm					
Date of Birth (DD/MM/YY) or Ag	e:	Ethnic Origin:	Race:					
Amoutation								
Amputation								
Did the patient have an amputa	tion?	☐ Yes ☐ No ☐ Unknown						
If yes, type of event:								
Trauma by accident	Surgical amputation	☐ Spontaneous/Non-Sur	gical 🔲					
Location of amputation:								
Left		Right						
Below knee		Below elbow						
Above knee		Above elbow						
Foot		Hand						
Big toe		Thumb						
Index toe		Index finger						
Middle toe		Middle finger						
Fourth toe		Ring finger						
Little toe		Little finger						

Case ID #:	
Manufacturer Date of Receipt:	

Amputation				
Trans metatarsal				
Other				
specify:				
Adverse event contributing to	/leading up to the amp	utation		
Adverse Event(s)	Start Date (DD/MM/YY)	End Date (DD/MM/YY)		Outcome
			Event ongoing R Specify Patient Died	Recovered with sequele
			Event ongoing R Specify Patient Died	Recovered with sequele
				Recovered with sequele
Diagnostic criteria and clinical dia examination and (c) clinical diagn	ngnosis of the event(s) (but osis of the event(s) leading	rief description, inclung up to the amputati	ding (a) symptor	ms, (b) Findings from physical
Was the patient hospitalized for the Yes ☐ No ☐ Unknown	ne event(s)?			
Was treatment provided?				
☐ Yes ☐ No ☐ Unknown				
If yes, please describe:				
Were there any complications cau	ised by the event(s)?			
☐ Yes ☐ No ☐ Unknown				
If yes, please describe:				
Dapagliflozin therapy				
Indication:	Daily dosage:	Start date (DI	D/MM/YY):	Stop date (DD/MM/YY):
Was dapagliflozin stopped or the	dosage altered due to the	e event(s)? Tyes, pe	rmanently \(\square\) Ye	es, temporarily \(\square\) No \(\square\) N/A
If yes, did the event(s) improve aff ☐ Yes, date stopped or dose chang		agliflozin? o □ N/A		
Was dapagliflozin re-introduced?		☐ Yes, date	re-introduced:	No N/A

Case ID #:	
Manufacturer Date of Receipt:	

Manufacturer Date of Receipt:									
Dapagliflozin therapy									
If yes, did the event(s) recu	r after reintroduction?	·	☐ Yes	, date recurred:	□	No □ N/A			
	Does the reporter consider there to be a causal relationship between dapagliflozin and the adverse event(s)? ☐ Yes ☐ No Please explain:								
Concomitant medications, including antidiabetic and diuretic medications (Exclude drugs to treat the event(s))									
Drug Name	Indication	Daily Dosage	Route	Start Date (DD/MM/YY)	Stop Date (DD/MM/YY)	Was this a suspect medication?			
						☐ Yes ☐ No			
						☐ Yes ☐ No			
						☐ Yes ☐ No			
Relevant medical history/ risk factors/concurrent diseases Please provide details: approximate dates of diagnosis and resolution if applicable									
Diabetes:		□Y€	es 🗆 No 🔲 L	INK					
Diabetes Type:		□Ту	уре I □Туре	II					
Date of Diabetes diagnosis:		Day:	Month:	Year					
Ankle-brachial pressure inde	x measured	□Y€	es ∐No ∐U	NK					
If yes, Date of measurement		Day:	Month:	Year					
Results:		_							
est. Glomerular Filtration Rat	te (eGFR) prior to treatn	nent 🔲 Ye	es 🗌 No 🔲 L	INK					
If yes, Date of measurement:		Day:	Month:	Year					
Result:									
Diabetic neuropathy			es 🗌 No 🔲 U						
Renal disease		□Ye	es ∐No ∐U	NK					

Case ID #:	
Manufacturer Date of Receipt:	

					
Relevant medical history/ risk	factors/concurrent	disease	S :f.annliaahla		
Please provide details: approximate	dates of diagnosis and	Tesolution TYes	□No □UNK		
Dehydration		□100			
Infection (of limb):					
		□\/00			
Wet gangrene		∐Yes	□No □UNK		
Non-healing infectious ulcer		∐Yes	□No □UNK		
Normaling inicologo dioo					
Osteomyelitis		∐Yes	□No □UNK		
Other Infection		∐Yes	□No □UNK		
Other intection					
If yes, please specify:					
Tobacco use					
Never smoked	Current smoker			Former smoker	
Tobacco stop date:		Dav:	Month:	Year	
Tobacco Stop date.		⊔ау	IVIOTIUT	1 eai	
If current or former smoker					
Amount of smokes/day:					
North and for any analysis as					
Number of years smoking:					
Tobacco type:					
Date and Signature					
Date:	-				
Signature (Reporting Physician):				·····	
Contact information					
Please return completed form to: Mail:					
Fax:	E-mail:				

Thank you for completing this form.

Urinary Tract Infection Questionnaire Request for Additional Information

Reporter information						
Reporter Name:		Reporter address: Telephone #: Fax #:				
Patient details						
Initials:	Sex: □	Male	Weight: ☐ Ib ☐ kg		Height:	in cm
Date of Birth (DD/MM/YY) or Ag	e:		Ethnic Origin:		Race:	
Adverse event details (for re	enal failu	re be specific abo	out chronicity: acu	ıte. chronic	or acute on c	hronic)
Adverse Event(s)		Start Date (DD/MM/YY)	End Date (DD/MM/YY)		Outco	·
					ngoing	
					ngoing Recovered red with sequele P	
					ngoing Recovered red with sequele P	
Diagnostic criteria and clinical performed:	diagnosi	s of the event(s) (b	rief description), pl	ease specify	how the diagn	osis was
Please also specify signs and the lower abdomen/pelvic are uncontrolled urge to pass urin suprapubic or perineal discomphils or sepsis:	a while pa e). Other Ifort, flank	assing urine, blood suggestive signs o	in the urine, and so or symptoms such a	ymptoms of uses dysuria, ur	urinary urgency gency or frequ	/ (a strong and lency of urination,
Fever? If yes, please add de	gree					
Was the patient hospitalized ☐ Yes ☐ No ☐ Unknown	I for the	event(s)?				
Was treatment provided? if ☐ Yes ☐ No ☐ Unknown	yes, ple	ase describe				

Urinary Tract Infection Questionnaire Request for Additional Information

Case ID #:	
Manufacturer Date of Receipt: _	

Manufacturer Date of Receipt:						
First event of urin	-	hile on treatment	with DAPA? if	no, please specif	y episode and d	late
Were there any co	-	used by the even	it(s)? if yes, plea	ase describe		
Did the patient red		bial medication?	if yes, please d	escribe		
Dapagliflozin therapy						
Indication:	ndication: Daily dosage: Start date (DD/MM/YY): Stop date (DD/MM/YY):					DD/MM/YY):
Was dapagliflozin s	topped due to th	e event(s)? Yes,	permanently :	Yes, temporarily	No N/A	
If yes, did the event(s) improve after stopping/altering dapagliflozin? ☐ Yes, date stopped or dose changed: ☐ No ☐ N/A						
Was dapagliflozin re	e-introduced?	Yes, date re-introdu	iced:			
If yes, did the event(s) recur after reintroduction? Yes, date recurred: No N/A						
Does the reporter consider there to be a causal relationship between dapagliflozin and the adverse event(s)? ☐ Yes ☐ No Please explain:						
Concomitant med	liantia una					
Exclude drugs used t		;)				
Drug Name	Indication	Daily Dosage	Route	Start Date (DD/MM/YY)	Stop Date (DD/MM/YY)	Was this also a suspect medication?
	_		_		_	☐ Yes ☐ No
						☐ Yes ☐ No ☐ Yes ☐ No

Urinary Tract Infection Questionnaire Request for Additional Information

Relevant medica				resolution if applicable		
T lease provide detail	із. арріс	oximate dates of di	agriosis aria	тезопинот и аррисаме		
- Catheter or urinary tract instrumentation/surgery:			surgery:	- Smoking: □Yes □No □UNK		
☐Yes ☐No ☐L	JNK			- Alcoholism: □Yes □No □UNK		
- Bladder patholog	Bladder pathology: ☐Yes ☐No ☐UNK		(- Glucocorticoid treatment: ☐Yes ☐No ☐UNK		
1	-			- Recent or ongoing treatment with antibiotics: ☐Yes ☐No ☐UNI		
1				- Birth control pills: ☐Yes ☐No ☐UNK		
- Estrogen deficier				·		
- Urine incontinend	•			Other, please specify:		
- Vesicoureteral re	eflux:]Yes □No □U	NK			
- Urethral obstruct						
- Recurrent UTI:						
Treatment of the Elevent						
Was any diagnostic test performed? (e.g. CRP, leucocyte count)						
Yes No Uknown; if yes, please describe belo			_			
	T					
Name of test		Test date		Results (describe abnormality)		
			□ Normal □ Abnormal, Describe:			
			□ Normal □ Abnormal, Describe:			
			☐ Normal	☐ Abnormal, Describe:		
Urinary culture p	erform	ed? 🗌 Yes 🔲 I	No 🗌 Unk	nown; if yes, tick below question		
Results indicative	e of UT	'I? 🗌 Yes 🔲 No	Unkno	own; if yes, please describe below		
Organism		Test date		Quantification		
			•			
	•			ntimicrobial treatment?		
Yes No	Unkno	wn, if yes, please	e describe	below		

Urinary Tract Infection Questionnaire Request for Additional Information

Case ID #:	
Manufacturer Date of Receipt:	

Date and Signature
Date:
Signature (Reporting Physician):
Contact information
Please return completed form to:
Fax:
E-mail:
Mail:

Thank you for completing this form.