OPTIMAL Transfer Form 13

Patient Initials	Date of Birth	Site Number	Trial Number
	d d - m m - y y y y	0	0

13.1 TRANSFER DETAILS:

1. Please provide the date the patient left the centre (dd/mm/yyyy): d d - m m - y y y y

2. Are the patient's new registration / ongoing monitoring arrangements known ? No ☐ Yes ☐

3. If Yes, please provide details below:

Name of new hospital:

New hospital number *(if applicable/known)*:

New consultant *(if known)*:

13.2 FOLLOW-UP DETAILS:

Please note all patients should remain on-study for follow-up and sampling purposes, unless the patient or clinician has specifically requested otherwise.

1. Is the patient happy for follow-up data to be collected? **No** ☐ **Yes** ☐ **Not Known** ☐

If No, please complete "Withdrawal and Lost to Follow-Up Form"

Please complete this form as soon as possible and fax/post to the OPTIMAL trial office

Clinical Trial Coordinator
Late Phase Haematology Research Team
Blue Portacabin
Churchill Hospital
Headington
Oxford
OX3 7LE

Fax 01865 572035

Completed by:
(Print)

CRFs should only be completed by appropriately qualified personnel detailed on the site delegation log

Signature:

Date completed: D D M M Y Y Y Y

For Office use only
Date form received: ______________________ Date form entered: ______________________ Initials: __________