OPTIMAL Death Form 16

Patient Initials | Date of Birth (d d – m m – y y y y) | Site Number (0) | Trial Number

To be completed upon patient's death.

Date of Death (dd/mm/yyyy)

Primary cause of Death*

(choose one option only from below)

1= Myeloma

2= Treatment related toxicity

3= Infection

4= Cardiac event

5= Renal failure

6= Other malignancy, please complete below:

Date confirmed (dd/mm/yyyy)

Type of cancer:

Site (s) of cancer:

7= Other, please specify:

Please ensure that in case of a death due to treatment related toxicity & complications an SAE Reporting Form is completed and faxed to the OPTIMAL Trial Office within 1 business day of site becoming aware of death.

Completed by:

(Print)

Signature:

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

Date completed: D D M M Y Y Y Y

For Office use only

Date form received: _____ Date form entered: _____ Initials: _____