FixDT

Centre ID | | | |

Six Week Follow-up Form

Participant ID | | | | |

Section 1

1. Has the patient been discharged from the admitting hospital? Yes ☐ No ☐

If **Yes**, what was the date of discharge?: (dd/mmm/yyyy) | | | | | | | | | |

2. Hospitalisation (Please add details about the patients stay in hospital to the table below)

Type of Ward	No. of days
Intensive Care Unit	
Acute Trauma Ward	
Rehabilitation Ward	
Other (Please specify).....	

3. Is the patient fully weight bearing? Yes ☐ No ☐

4. Has the patient been referred to physiotherapy? Yes ☐ No ☐

If **Yes**, has the patient been discharged from physiotherapy? Yes ☐ No ☐

If **Yes**, please give the date (dd/mmm/yyyy): | | | | | | | | | |

Section 2—Trial Wound Complications

1. Following treatment did any of the following complications occur?:

If **Yes** complete questions 1-3. If **No**, please tick No and move to Section 3

Yes ☐ No ☐ If **Yes**, tick all that apply:

	Yes	No
Erythema (increasing redness around wound edges)	☐	☐
Persistent serous drainage longer than 5 days	☐	☐
Purulent drainage	☐	☐
Dehiscence	☐	☐
Microbiological confirmation of infection	☐	☐

If **Yes**, which bacteria?.....

2. Were complications related to the injury treated by any of the following methods?:

Yes ☐ No ☐ If **Yes**, tick all that apply:

	Yes	No
Metal removal	☐	☐
Surgical debridement	☐	☐
Antibiotics	☐	☐

Please give details of the antibiotics in the table below:

Antibiotic Type	Dose	Times Per Day	Duration

3. If injury complications were treated surgically, please give details:

Surgery 1: Date (dd/mmm/yyyy): ☐☐ ☐☐☐ ☐☐☐☐

Surgeon..... Hospital.....

Details (including type of surgery).....

Surgery 2: Date (dd/mmm/yyyy): ☐☐ ☐☐☐ ☐☐☐☐

Surgeon..... Hospital.....

Details (including type of surgery).....

Section 3 —Trial Fracture Healing

1. In the opinion of the Principal investigator have any of the following elements of radiological malunion occurred as present on the 6 week x-ray?

	Yes	No
AP (>5° Angular Deformity)	☐	☐
Lateral (> 10° Recurvatum/ Procurvatum)	☐	☐
Shortening > 10mm	☐	☐

2. In the opinion of the Principal Investigator is there any:

Failure of the metal work? Yes ☐ No ☐

Clinical Mal-rotation? Yes ☐ No ☐

Section 4

1. As a result of the treatment for the injury being investigated by FixDT, has the patient had any of the following?:

Neurological injury Yes ☐ No ☐

If Yes, what was the injury?.....

.....

Please describe treatment.....

.....

.....

Vascular injury Yes ☐ No ☐

If Yes, what was the injury?.....

.....

Please describe treatment.....

.....

.....

Tendon injury Yes ☐ No ☐

If Yes, what was the injury?.....

.....

Please describe treatment.....

.....

.....

2. Has the patient had a diagnosis of:

Complex Regional Pain Syndrome Yes ☐ No ☐

If Yes, please give details.....

.....

Please describe treatment.....

.....

.....

DVT Yes ☐ No ☐

If Yes, please give details.....

.....

Please describe treatment.....

.....

.....

PE Yes ☐ No ☐

If Yes, please give details.....

.....

Please describe treatment.....

.....

.....

Other significant pathology Yes ☐ No ☐

If Yes, please give details.....

.....

Please describe treatment.....

.....

.....

Section 5

1. Compared to how the patient felt when admitted to hospital do they feel (Tick one box only)

The Same	☐	A Lot Better	☐
A Little Better	☐	Almost Back to Normal	☐
Moderately Better	☐	Back to Normal	☐

Section 6 –Patient contact details

1. Has the patient changed or is likely to change any contact details over the next three months? Yes ☐ No ☐

If **Yes**, have you completed a 'Change of Contact Details' form Yes ☐ No ☐

If **No**, please complete the 'Change of Contact Details' form as found in the expanding trial documents folder.

Research Associate signature:

.....

Date (dd/mmm/yyyy):