

**TERMINATION OF STUDY  
PARTICIPATION**

**TERM**

Patient ID: 1 \_\_\_\_\_  
 Patient Initials: \_\_\_\_\_  
 Last Visit Number: \_\_\_\_\_  
 Last Visit Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month      day      year  
 Interviewer ID: \_\_\_\_\_

*(Clinic Coordinator completed)*

**Please indicate the reason(s) for termination of study participation.**

- 01** 1. **(Visit 12 Only)**  
 Has the patient completed the study? <sub>1</sub> Yes <sub>0</sub> No  
 If **Yes**, proceed to page 2.
- 02** 2. **(Visits 1 - 4 Only)**  
 During the run-in period, has the patient experienced a significant asthma exacerbation as defined in the Manual of Operations? <sub>1</sub> Yes <sub>0</sub> No
- 03** 3. Did the patient have a positive pregnancy test? <sub>1</sub> Yes <sub>0</sub> No
- 04** 4. Has the patient withdrawn consent? <sub>1</sub> Yes <sub>0</sub> No
- 04A** If **Yes**, indicate the **primary** reason.  
<sub>1</sub> no longer interested in participating  
<sub>2</sub> no longer willing to follow protocol  
<sub>3</sub> access to clinic is difficult (location, transportation, parking)  
<sub>4</sub> unable to make visits during clinic hours  
<sub>5</sub> unable to continue on study due to personal constraints  
<sub>6</sub> dissatisfied with lack of asthma control  
<sub>7</sub> unable to continue due to medical condition unrelated to asthma  
<sub>8</sub> treatment failure  
<sub>9</sub> other \_\_\_\_\_
- 05** 5. **(Visits 1 - 4 Only)**  
 Has the patient been deemed ineligible according to any eligibility criteria **other** than those already listed? <sub>1</sub> Yes <sub>0</sub> No
- 06** 6. Is there any other reason for which the patient will no longer be participating in the study? <sub>1</sub> Yes <sub>0</sub> No

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Patient ID:   1   \_\_\_\_\_

Last Visit Number: \_\_\_\_\_

***Please complete the following section regardless of the reason for termination of study participation.***

I verify that all information collected on the ACRN BAGS data collection forms for this patient is correct to the best of my knowledge and was collected in accordance with the procedures outlined in the ACRN BAGS Protocol and Manual of Operations.

**S1**

**DT1**

\_\_\_\_\_

Clinic Coordinator Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month    day    year

**S2**

**DT2**

\_\_\_\_\_

Principal Investigator Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
month    day    year