ID#: CLU: **«clu_study_id»** Form: 1 0 Ver: 0 2

Cause of Death Form

Please complete this form for patients who died since enrollment in the Carolina Lupus Study.

Patient's Name: **«f_name» «m_name» «l_name»**

Date of Birth: **«scr_birth_date»**

Doctor's Name: **Dr. «fname» «referral_text»** Doctor ID: **«ref_source»**

Date of Last Office Visit: ___ / ___ / ____
(month) (day) (year)

Date of Death: ___ / ___ / ____ *(please give approximate date, i.e., year or month and year if exact date is not known)*
(month) (day) (year)

Immediate cause of death: _____

Underlying cause(s) of death: _____

OR ☐ Don't have information on cause of death

Would you say lupus:

1 ☐ was directly related to the patient's death

2 ☐ contributed to the patient's death

3 ☐ was not related to the patient's death

Date Completed: ___ / ___ / ____
(month) (day) (year)

***Please return completed forms in stamped, addressed envelope to**:*

Glinda Cooper, PhD, (NIEHS)
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P.O. Box 12233
Research Triangle Park*, N.C. 27709*

c/o Heidi Staub
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