	/ATE Resource Data Colilled by Patient	llection	She	eet	Date	e:/	Visi	it no:		Study ID No.				1 1	ient ials:
or alle	your last visit for this st ergic reactions of nose a re you been to hospital? (A	nd/or e	yes:											·	est infection eet(s) of paper)
				ut-	Admitte	period), did				ne take ti nsport or				axi, Āmbu	hospital? By bus, llance, paid carer,
Date	What was (were) the reason(s)?	? A8	E pat	tient ye	s No. n	off work? (days/ho		How m	nuch? Hours	Th	eir job?		frien	d, your car?
] []				,						
			ן ו		ם	days	hours	d	ays	Hours					
] []	days	hours	d	ays	Hours					
] []	days	hours	d	ays	Hours					
	I .														
	e you been to see, or called, and the property of the property	sychologis	st, acu	puncti	ırist, em			th pro			alteri	ative			time off work to
For exar	nple: physiotherapist, homeopath, p	sychologis Who did	you	How :	urist, em seen?	Where? (home, surgery, c	linic,		When?		For yo	u: time	- Any ti	one take	time off work to
		sychologis	you	How son person	seen?	where?	linic,	rgery hrs,	When? 6-10PM,	10PM-8AM	For yo		- Any ti	one take	time off work to
For exar	nple: physiotherapist, homeopath, p	sychologis Who did	you	How :	urist, em seen?	Where? (home, surgery, c	linic,		When?		For yo	u: time /ork?	Any ti time o	one take ansport of work?	time off work to
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For exar	nple: physiotherapist, homeopath, p	sychologis Who did	you	How :	seen? phone	Where? (home, surgery, c	linic,	rgery hrs,	When? 6-10PM,	10PM-8AM	For you off volume	u: time /ork? hours	Any time of days	vone take cansport of off work? hours	time off work to
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For exar	nple: physiotherapist, homeopath, p	sychologis Who did	you	How : n person	seen? n phone	Where? (home, surgery, c	linic,	rgery hrs,	When? 6-10PM,	10PM-8AM	For younger of the days days days days	u: time /ork? hours hours	Any time of days days days	vone take cansport of the canaparate of the cansport of the ca	time off work to
For exar	nple: physiotherapist, homeopath, p	sychologis Who did	you	How son person	seen? phone	Where? (home, surgery, c	linic,	rgery hrs.	When? 6-10PM,	10PM-8AM	For you off votages days days days	u: time vork? hours hours hours hours	Any time of days days days days	hours hours hours hours	time off work to

^{** &}quot;last visit" refers to the previous scheduled visit to your GP for the ELEVATE Study. The 7 scheduled study visits are at 0, 2, 10, 26, 52, 78 & 104 weeks.

To be fille	To be filled by Patient				Date:/ Visit r			no: ID No.		initials	S :
3. Have	you bough	sit, due to asthma at anything from phonines, analgesics, nicotine escription items (eg. inhalo	armacy, or so	ome of	<i>ther so</i> r, cleani	O <i>urce,</i> i	to help s, specia	you w	<i>rith your health</i> g, air conditioner, hu	? midifier, nebuliser, ioni	_
Date		What did you purc		- g , .		Cost			Why purch		7
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4. Have	there been Did you treat	any other occasion What did you do, or use,	ns when your a Did you take			days off			n you had to take e time off for you?	Any other costs?	
Date	yourself?	in self-treating?	time off work?		cify days			ff work?	Their job?	comments?	
	-			days	hou	ırs	days	hours			
				days	hou	ırs	days	hours			
				days	hou	ırs	days	hours			
				days	hou		days	hours			
				days	hou	ırs	days	hours			

Date: ___/

Study

ID No.

Visit no:

Patient

initials:

Please collect the resource diary from the patient and post it to the study office along with this and the other forms.

ELEVATE Resource Data Collection Sheet

ELEVATI	E medic	ation			Study
follow up.	Patient		Date://	Visit no: 6	ID No. 110157
	initials:	DM		•	

If any questions about filling this form – feel free to write out a brief description on the reverse.

All Medications										
Asthma, other respiratory problems or respiratory tract infections and other health issues.										
DRUG NAME	ROUTE	TOTAL DAILY DOSAGE Dose Units	START DATE (DD Mon-YYYY)	STOP DATE (DD Mon-YYYY)	WHY? If new: name of medical condition being treated – If dosage change: reason	Adverse Event?				
						If Yes				
						If Yes □				
				/		If Yes				
				/		If Yes □				
			//			If Yes □				
						If Yes □				
			/			If Yes				
			/			If Yes				
			/			If Yes				
				/		If Yes □				
			/	/		If Yes □				
			/			If Yes □				
						If Yes				
						If Yes				
						If Yes				

Drug Name: use generic name except: use trade name for fixed combinations only, and use trade name for medications with multiple active ingredients. **Route:** PO (oral), IV (intravenous infusion), IM (intramuscular), INH (inhalant), Other.

- Please list **ALL** medications taken since last study visit.
- Repeat prescriptions should only be listed one time.
- <u>Dose</u> total mg or mcg for the entire day for a drug taken on an "as needed" basis, write "as needed"
- <u>Start date</u>: if medication has been taken long term, but dosage changed, use date when current specific dosage started. NB: <u>Dates can be approximate -don't have to be precise.</u>

If total daily dose changes, make an additional entry.

- Stop date: Only specify this date if drug is discontinued or dosage is changed. Date can be approximate.
- Why: Give medical indication for discontinuation or dosage change
- Adverse Event? Only tick yes box if an adverse event occurs.