

Cause of Death Form (CRF)



*Study: _____

*Patient ID code: _____

*Date of death : ____ - ____ - ____
(dd/mm/yy eg 01-FEB-05)

Section 1 ♦ Background demographics

- * A. Year of birth (yyyy) _____
- B. Gender : male female
- C. Height (cm) : _____
- D. Weight (kg) : _____
(most recent before death)
- E. Date : ____ - ____ - ____
(dd-mm-yy; weight measured)

Section 2 ♦ What data sources were available for the completion of this form? (please mark all that apply)

- A. Hospital files Yes, complete Yes, incomplete No
- B. Outpatient clinic chart Yes, complete Yes, incomplete No
- C. Autopsy report Yes, complete Yes, incomplete No

If other, specify:

- D. Registry
- E. Obituary
- F. Patient's relatives or partner
- G. Patient's medical provider
- H. Nursing home
- I. Other: _____

Section 3 ♦ Risk factors:

A. Ongoing risk factors in the year prior to death:

- 1. Cigarette smoking Yes No Unknown
- 2. Excessive alcohol consumption Yes No Unknown
- 3. Active illicit injecting drug use Yes No Unknown
- 4. Active illicit non-injecting drug use Yes No Unknown
- 5. Opiate substitution (methadone) Yes No Unknown

Section 4 ♦ Co-morbidities:

A. Ongoing chronic conditions:

- 1. Hypertension Yes No Unknown
- 2. Diabetes mellitus Yes No Unknown
- 3. Dyslipidemia Yes No Unknown

B. Prior cardiovascular disease

(myocardial infarction, stroke or invasive cardiovascular procedure)

- Yes No Unknown

C. History of depression

- Yes No Unknown

D. History of psychosis

- Yes No Unknown

E. Liver disease:

- 1. Chronic elevation of liver transaminases Yes No Unknown
- 2. Chronic HBV infection Yes No Unknown
- 3. Chronic HCV infection Yes No Unknown
- 4. HDV infection Yes No Unknown
- 5. History of previous liver decompensation Yes No Unknown
- 6. Clinical signs of liver failure in the 4 weeks before death Yes No Unknown
- 7. Liver histology available (ever) Yes No Unknown

If Yes, please indicate: the date of most recent biopsy _____ the stage of fibrosis (0-4):

(dd-mm-yy eg 01-FEB-05)

* Please note that if any of the mandatory fields remain empty the CRF will not be registered

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Section 5 ♦ Cause of death

A. Was the death sudden? Yes No Unknown

B. Was the death unexpected? Yes No Unknown

C. Please complete the table below by recording all illnesses and conditions (acute and chronic) or injuries that the patient had at the time of death.

	Illness / Condition / Injury (text)	Date of onset dd/mm/yy (eg 01-FEB-05)	Certainty of diagnosis ^a		
			Definite	Likely	Possible
1.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.		___ - ___ - ___	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

^aCertainty of Diagnosis: Definite = 95-100% certainty, Likely = 80-95% certainty, Possible = 50-80% certainty

* D. Brief narrative of the sequence of events leading to death (please include means of diagnosis of illnesses):

E. In summary, the causal relation between the conditions leading to death was (complete this section with the corresponding number from table C above):

1. Condition that directly caused death (immediate cause): _____
2. Due to or as a consequence of: _____
3. Due to or as a consequence of: _____
4. Condition that initiated the train of morbid events (the underlying condition): _____

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Section 8 ♦ Adverse effects to any type of medical treatment:

A. Was the death considered to be related to a medical treatment? Yes No Possibly

B. The suspected relation was to: Antiretroviral treatment Other medical treatment

Please provide a brief narrative of the suspected association including the name of the medication and the date of starting:

Please refer to the 'CoDe instructions' for definitions and guidelines for the completion of this form

Completed by: Name (in print): _____

Position : Physician Nurse Other (describe) : _____

Directly involved in the medical care of the patient around the time of death? Yes No

Date (dd/mmm/yy): ___ - ___ - ___

Signature: _____

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