

Concomitant Medications (Con Med) Log [Ongoing Logs]

Date documenting medication: ___ / ___ / _____ (dd/mm/yyyy)		
Medication name: _____ ⓘ Generic Medication name may be used	Indication: _____	Was med taken for a reported AE? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dose: _____		
Units: <input type="checkbox"/> Grams <input type="checkbox"/> Micrograms <input type="checkbox"/> Milligrams <input type="checkbox"/> Milliliters <input type="checkbox"/> Capsules <input type="checkbox"/> Drops <input type="checkbox"/> Puffs <input type="checkbox"/> Sachets <input type="checkbox"/> Suppository <input type="checkbox"/> Tablets <input type="checkbox"/> Units <input type="checkbox"/> Unknown <input type="checkbox"/> Other (if "Other", specify below) ↓	Frequency: <input type="checkbox"/> prn <input type="checkbox"/> once <input type="checkbox"/> qd <input type="checkbox"/> bid <input type="checkbox"/> tid <input type="checkbox"/> qid <input type="checkbox"/> qm <input type="checkbox"/> qh <input type="checkbox"/> unknown <input type="checkbox"/> other ↓	Route: <input type="checkbox"/> Oral <input type="checkbox"/> subdermal <input type="checkbox"/> Intramuscular <input type="checkbox"/> Intravenous <input type="checkbox"/> Topical <input type="checkbox"/> Subcutaneous <input type="checkbox"/> Inhalation <input type="checkbox"/> Vaginal <input type="checkbox"/> Rectal <input type="checkbox"/> Intrauterine <input type="checkbox"/> Epidural <input type="checkbox"/> Unknown <input type="checkbox"/> Other ↓
Other unit: _____ ⓘ Complete only if "Other" unit marked above.	Other frequency: _____ ⓘ Complete only if "other" frequency marked above.	Other route: _____ ⓘ Complete only if "Other" route marked above.
Date med started: ___ / ___ / _____ (dd/mm/yyyy) ⓘ REDCap will allow for date estimates	Continuing at end of study? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date med stopped: ___ / ___ / _____ (dd/mm/yyyy) ⓘ REDCap will allow for date estimates

CRF Completed By: _____ (initials)

CRF Completion Date: ___ / ___ / _____ (dd/mm/yyyy)