NHS Hull University Teaching Hospitals NHS Trust

UNIVERSITY of York

Participant ID: ☐☐☐☐

SWHSI-2 Supplementary Page for Inpatient Admissions

Please continue to record any inpatient admissions (in addition to those recorded in the 12M Resource Use CRF)

Admission Date	Surgical Intervention Provided	Other Treatment Provided	Discharge Date	Adverse Event
☐☐ / ☐☐ / ☐☐☐☐ *Day* *Month* *Year*	Yes ☐ No ☐ If Yes, please tick all that apply: Amputation ☐ Angloplasty ☐ Incision & Drainage ☐ Debridement ☐ Revascularisation ☐ Wound Closure ☐ ☐ Other, please specify	Yes ☐ No ☐ If Yes, please tick all that apply: Analgesia ☐ Antibiotic ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ ☐ Other, please specify	☐☐ / ☐☐ / ☐☐☐☐ *Day* *Month* *Year*	Reported? Yes ☐ No ☐ AE Number ☐☐
☐☐ / ☐☐ / ☐☐☐☐ *Day* *Month* *Year*	Yes ☐ No ☐ If Yes, please tick all that apply: Amputation ☐ Angloplasty ☐ Incision & Drainage ☐ Debridement ☐ Revascularisation ☐ Wound Closure ☐ ☐ Other, please specify	Yes ☐ No ☐ If Yes, please tick all that apply: Analgesia ☐ Antibiotic ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ ☐ Other, please specify	☐☐ / ☐☐ / ☐☐☐☐ *Day* *Month* *Year*	Reported? Yes ☐ No ☐ AE Number ☐☐

Admission Date	Surgical Intervention Provided	Other Treatment Provided	Discharge Date	Adverse Event
☐☐ / ☐☐ / ☐☐☐☐ Day Month Year	Yes ☐ No ☐ If Yes, please tick all that apply: Amputation ☐ Angloplasty ☐ Incision & Drainage ☐ Debridement ☐ Revascularisation ☐ Wound Closure ☐ ☐ Other, please specify	Yes ☐ No ☐ If Yes, please tick all that apply: Analgesia ☐ Antibiotic ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ ☐ Other, please specify	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year	Reported? Yes ☐ No ☐ AE Number ☐☐
☐☐ / ☐☐ / ☐☐☐☐ Day Month Year	Yes ☐ No ☐ If Yes, please tick all that apply: Amputation ☐ Angloplasty ☐ Incision & Drainage ☐ Debridement ☐ Revascularisation ☐ Wound Closure ☐ ☐ Other, please specify	Yes ☐ No ☐ If Yes, please tick all that apply: Analgesia ☐ Antibiotic ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ ☐ Other, please specify	☐☐ / ☐☐ / ☐☐☐☐ Day Month Year	Reported? Yes ☐ No ☐ AE Number ☐☐

Form Completed by:

Name: ______________________________ Assessor ID: ☐☐ Date: ☐☐ / ☐☐ / 20☐☐ (Day / Month / Year)