Participant ID: ☐☐☐☐

SWHSI-2 Supplementary Page for Accident and Emergency Visits

Please continue to record any Accident and Emergency visits (in addition to those recorded in the 12M Resource Use CRF)

Visit Date	Intervention provided	Was the patient admitted as an inpatient following the visit?	Adverse Event
☐☐ / ☐☐ / ☐☐☐☐ *Day* *Month* *Year*	☐ Antibiotic ☐ Analgesia ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ Other, please specify	Yes ☐ No ☐	Reported? Yes ☐ No ☐ AE Number ☐☐
☐☐ / ☐☐ / ☐☐☐☐ *Day* *Month* *Year*	☐ Antibiotic ☐ Analgesia ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ Other, please specify	Yes ☐ No ☐	Reported? Yes ☐ No ☐ AE Number ☐☐
☐☐ / ☐☐ / ☐☐☐☐ *Day* *Month* *Year*	☐ Antibiotic ☐ Analgesia ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ Other, please specify	Yes ☐ No ☐	Reported? Yes ☐ No ☐ AE Number ☐☐

Visit Date	Intervention provided	Was the patient admitted as an inpatient following the visit?	Adverse Event
☐☐ / ☐☐ / ☐☐☐☐ *Day Month Year*	☐ Antibiotic ☐ Analgesia ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ Other, please specify	Yes ☐ No ☐	Reported? Yes ☐ No ☐ AE Number ☐☐
☐☐ / ☐☐ / ☐☐☐☐ *Day Month Year*	☐ Antibiotic ☐ Analgesia ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ Other, please specify	Yes ☐ No ☐	Reported? Yes ☐ No ☐ AE Number ☐☐
☐☐ / ☐☐ / ☐☐☐☐ *Day Month Year*	☐ Antibiotic ☐ Analgesia ☐ Larvae ☐ Topical Treatments ☐ Wound Management Systems ☐ Other, please specify	Yes ☐ No ☐	Reported? Yes ☐ No ☐ AE Number ☐☐

Form Completed by:

Name: ______________________________ Assessor ID: ☐☐ Date: ☐☐ / ☐☐ / 2 0 ☐☐
Day Month Year