

Participant Screening Log

Patient initials (forename, surname)	Date of Birth (dd/mm/yyyy)	Gender (m/f)	Screening date (dd/mm/yyyy)	Eligibility	If not eligible, primary reason	Consent obtained	Enrolled	If not enrolled, primary reason	Date enrolled (i.e, date consent form was signed) (dd/mm/yyyy)
				<input type="checkbox"/> Eligible <input type="checkbox"/> Eligible but declined <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Consent withdrawn <input type="checkbox"/> No longer eligible <input type="checkbox"/> Other: _____	
				<input type="checkbox"/> Eligible <input type="checkbox"/> Eligible but declined <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Consent withdrawn <input type="checkbox"/> No longer eligible <input type="checkbox"/> Other: _____	
				<input type="checkbox"/> Eligible <input type="checkbox"/> Eligible but declined <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Consent withdrawn <input type="checkbox"/> No longer eligible <input type="checkbox"/> Other: _____	
				<input type="checkbox"/> Eligible <input type="checkbox"/> Eligible but declined <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Consent withdrawn <input type="checkbox"/> No longer eligible <input type="checkbox"/> Other: _____	
				<input type="checkbox"/> Eligible <input type="checkbox"/> Eligible but declined <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Consent withdrawn <input type="checkbox"/> No longer eligible <input type="checkbox"/> Other: _____	
				<input type="checkbox"/> Eligible <input type="checkbox"/> Eligible but declined <input type="checkbox"/> Not Eligible <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Consent withdrawn <input type="checkbox"/> No longer eligible <input type="checkbox"/> Other: _____	