New Drug A: Protocol No. NDP-1003

CCRP Pharmaceuticals, Inc.
1 Main Street, Boston, MA 02125

Follow –up visit number:	**02**	**Code Number:**	_____ _____ _____
Visit Date (mm-dd-yy):	___ ___-___ ___-___ ___		

1. **Physical Exam Completed:** ☐ Yes ☐ No

2. Vital Signs *(Complete all blanks with numerical value)***:**

BP _____ ____ ____ / ____ ____ ____

Pulse _____ _____ _____

Respirations _____ _____

Temperature ___ ___ ___ • ___ °F

Body Weight ____ ____ ____ • ___ kg.

3. Signs and Symptoms of Pneumonia *(Tick all that apply):*

Symptom	Yes	No
a. Cough		
b. Fever > 101°F		
c. Production of Sputum		
d. Rales		
e. Pleuritic chest pain		

4. Clinical Response *(Tick only one):*

a. Cure ☐
b. Improved ☐
c. Failure ☐
d. Relapse ☐
e. Unable to Evaluate ☐

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7. Identify Adverse Events that occurred since last completed follow-up visit. Complete *Protocol NDP – 1003 Adverse Event Form (790)* for all adverse events that are identified below. *(Tick all that apply)*:

	Symptom	Yes	No	Probably Related	Possibly Related	Unknown if Related	Not Related
a.	Gastrointestinal						
	i. nausea						
	ii. diarrhea						
	iii. vomiting						
	iv. other						
b.	Metabolic disorder						
	i. elevated SGOT						
	ii. elevated SGPT						
	iii. elevated creatinine						
	iv. elevated BUN						
	v. other						
c.	Nervous system						
	i. dizziness						
	ii. restlessness						
	iii. tremor						
	iv. headache						
	v. other						
d.	Dermotologic						
	i. rash						
	ii. other						
e.	Other						
f.	Other						
g.	Other						

8. Drug Compliance- Indicate the number of pills taken_____ remaining_____

Signature (PI or CRC)**:** _____

Certification Number: ____ ____ ____ ____ ____ **Date:** ____ ____-____ ____-____ ____(mm-dd-yy)