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| **NHS Trust/Health Board Name:** |  |
| Address:  Postcode: |  |
| **Participating Hospital Name(s):** |  |
| Address:  Postcode: |  |

*(Examples are provided in green italicised text in brackets and should be removed by the site)*

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| Please indicate where the following records will be located during the trial and how they can be accessed by the trial monitor and/or auditor. | | | |
| **Source Document** | **Format** | **Location**  *(include department /address if different from main location of study)* | **Access**  *(Where printed out, signed and dated please indicate so)* |
| Informed Consent Form | *(Paper)* | *(Medical records in hospital & Investigator site file held in research office)* | *(File & paper notes provided by Research team)* |
| Informed consent process |  |  |  |
| Eligibility decision (*including inclusion & exclusion criteria)* |  |  |  |
| Medical History/Notes | *(Electronic)* | *(EMR system)* | *(Granted upon completion of Trust IT form)* |
| Clinic Letters |  |  |  |
| Inpatient records |  |  |  |
| GP Letter |  |  |  |
| Provision of study contact card |  |  |  |
| Adverse events including grade and causality assessment by an investigator |  |  |  |
| Study specific records / source data worksheets |  |  |  |
| Biochemistry, haematology, hepatitis serology, pregnancy test, autoimmune conditions and other blood results |  |  |  |
| Lung function test results |  |  |  |
| ceCT/PET-CT Scans & Reports |  |  |  |
| X-rays & reports |  |  |  |
| ECGs/ Echocardiogram |  |  |  |
| Concomitant medication |  |  |  |
| Nivolumab dosing /administration & traceability information, prescriptions | *(Electronic)* | *(Chemocare system)* | *(Printed out signed and dated)* |
| Assessment for Stem Cell Transplant (ASCT or alloSCT |  |  |  |
| Transplant related mortality/ complications |  |  |  |

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| **If applicable, please detail any plans for transfer of paper medical records to electronic records, including any intended destruction of the original paper records.** |

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| **Signed (by Clinical Trial Coordinator / Research Nurse):** |  |
| **Signed:** | **Date:** |

**Please email to** [**ctc.animate@ucl.ac.uk**](mailto:ctc.animate@ucl.ac.uk) **and file original in the Investigator Site File**

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| **THIS PAGE IS FOR UCL CTC USE ONLY** | | | | | | | |
| Date form received: | |  | | | | | |
| CTC Electronic Medical Records Questionnaire required (**see SOP T25**)? | | | | Yes |  | No |  |
| **Notes:** | | | | | | | |
| **Checked by (TC/STC):** | | | Date: |  | | | |
| Print Name: |  | | Signature: |  | | | |
| **Completed form must be filed in the CTC Site File.** | | | | | | | |