Has the participant had any adverse events during the study?[ ]  No [ ]  Yes

**Table 1 Record diagnoses (if known) or signs/symptoms the participant experienced during the study that qualify as adverse events**

| Adverse Event | Onset Date and Time | Site AE Awareness Date | Ongoing? | Resolution Date | Severity | Investigator Assessment of Study Intervention Causality | Action Taken with Study Intervention | Other Action Taken | Outcome Attributed to the Event | Serious Adverse Event?[[1]](#footnote-1) | Unexpected Adverse Event?[[2]](#footnote-2) | IRB Notified?[[3]](#footnote-3) |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Data to be filled in by site | Data to be filled in by site | Data to be filled in by site | [ ]  No[ ]  Yes | Data to be filled in by site | [ ]  Mild[ ]  Moderate[ ]  Severe | [ ]  Unrelated[ ]  Unlikely[ ]  Possible [ ]  Probable[ ]  Definite | [ ]  None[ ]  Study Intervention Interrupted[ ]  Study Intervention Discontinued [ ]  Study Intervention Modified[ ]  Other, specify: | [ ]  None[ ]  Non-Study Treatment Required | [ ]  Recovered/Resolved [ ]  Recovered/Resolved with Sequelae[ ]  Recovering/Resolving[ ]  Not Recovered/Not Resolved[ ]  Fatal | [ ]  No[ ]  Yes | [ ]  No[ ]  Yes | [ ]  No[ ]  Yes |
| Data to be filled in by site | Data to be filled in by site | Data to be filled in by site | [ ]  No[ ]  Yes | Data to be filled in by site | [ ]  Mild[ ]  Moderate[ ]  Severe | [ ]  Unrelated[ ]  Unlikely[ ]  Possible[ ]  Probable[ ]  Definite | [ ]  None[ ]  Study Intervention Interrupted[ ]  Study Intervention Discontinued [ ]  Study Intervention Modified[ ]  Other, specify: | [ ]  None[ ]  Non-Study Treatment Required | [ ]  Recovered/Resolved[ ]  Recovered/Resolved with Sequelae[ ]  Recovering/Resolving[ ]  Not Recovered/Not Resolved[ ]  Fatal | [ ]  No[ ]  Yes | [ ]  No[ ]  Yes | [ ]  No[ ]  Yes |

Recorder Signature: Date:

## General Instructions

Important note: None of the data elements included on this CRF are classified as Core (i.e., strongly recommended for all clinical studies to collect). All of the data elements are classified as Supplemental and should only be collected if the research team considers them appropriate for their study.

### **ADVERSE EVENTS**

Adverse events (AEs) document any unfavorable or untoward medical occurrence that is observed with use of a drug or medical device in a participant enrolled in a study without regard for cause or relationship. AEs are the construct through which the safety of an intervention is recorded and assessed during a study. Typical AE descriptors include event dates of onset and resolution, severity, causality, outcome, and seriousness.

### **RECORDING ADVERSE EVENTS**

All AEs, both serious and non-serious, regardless of relationship to the study intervention, should be recorded on the AE CRF. AE data should be collected from the time the informed consent form is signed through the duration of the clinical investigation. Standard medical terminology should be used when recording AEs. Furthermore, it is recommended that studies that plan to submit data to regulatory authorities should code their AE data using the Medical Dictionary for Regulatory Activities (MedDRA): [https://www.meddra.org/](http://www.meddra.org/) or Common Terminology Criteria for Adverse Events (CTCAE): [https://ctep.cancer.gov/protocolDevelopment/electronic\_applications/ctc.htm](http://ctep.cancer.gov/protocolDevelopment/electronic_applications/ctc.htm).

### **SERIOUS ADVERSE EVENTS**

A serious adverse event (SAE) is defined as any untoward medical occurrence that: results in death; is a life-threatening medical situation; requires inpatient hospitalization or prolongation of existing hospitalization; results in persistent or significant disability or incapacity; is a congenital anomaly or birth defect; or is an important medical event.

Important medical events that may not result in death, be life threatening, or require hospitalization may be considered a serious adverse event when, based upon appropriate medical judgment, they may jeopardize the participant and may require medical or surgical intervention to prevent one of the outcomes listed in this definition. Examples of such medical events include allergic bronchospasm requiring intensive treatment in an emergency room or at home, blood dyscrasias or convulsion that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse.

If an event is documented as serious, then a separate SAE Report form must be completed. For studies under a Food and Drug Administration (FDA) Investigational New Drug (IND) application, a 3500A is completed and submitted as an expedited report, if the event is also unexpected and related to the study intervention. Because the data collected for an SAE are descriptive and beyond the scope of a study, the SAE information is usually kept in a separate file. In addition to the SAE descriptors, it is useful to track when the SAE is sent to the Institutional Review Board (IRB), sponsor, FDA, and Data Safety Monitoring Board (DSMB) and responses are received.

In some neurological studies, there has been confusion over the relationship between a study endpoint (e.g., myocardial infarction) and an SAE. The AE may be heart attack, described as mild. However, since it resulted in a hospitalization, it is coded as “serious” (SAE). The event may also be a study endpoint that is captured on the SAE form and sent for adjudication. This process would be tracked but the information collected is generally beyond the study scope and is not captured on study CRFs nor entered into the study data management system.

Further safety reporting requirements for adverse events that occur during clinical trials using investigational medication(s) or device(s) can be found on the U.S. Food and Drug Administration website: [U.S. Food and Drug Administration Investigational New Drug Reporting Requirements](https://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ApprovalApplications/InvestigationalNewDrugINDApplication/ucm226358.htm)

## Specific Instructions

Please see the Data Dictionary for definitions for each of the data elements included in this CRF Module.

* Any Adverse Events During the Study – Choose one. If answered YES, at least one AE must be recorded in Table 1.
* Definition of AE – Any untoward medical occurrence in a study participant that does not necessarily have a causal relationship with the study intervention. An AE can therefore be any unfavorable and unintended sign (including an abnormal laboratory finding), symptom, or disease temporally associated with the use of a study intervention or study procedure, whether or not related to the study intervention or procedure. Each AE should be listed on a separate row of the table. Any worsening of a baseline condition or reoccurrence of a baseline condition that had previously ended for a time should be listed as an AE. Events, such as nausea and vomiting are considered two events, and therefore should be listed on separate lines. A participant may experience an unexpected AE. An unexpected adverse reaction has a nature or severity of which is not consistent with the study intervention description (e.g., Investigator's Brochure for an unapproved investigational product or package insert/summary of product characteristics for an approved product). The unexpected AE must be reported, whether related to the study intervention or not, with as much detail as is available. See the Data Dictionary for additional information on coding the adverse events using either the Common Terminology Criteria for Adverse Events (CTCAE) or the Medical Dictionary for Regulatory Activities (MedDRA).
* Onset Date and Time – Record the date and time the adverse event started. Record the date/time according to the [ISO 8601](https://www.iso.org/home.html), the International Standard for the representation of dates and times. The date/time should be recorded to the level of granularity known (e.g., year, year and month, complete date plus hours and minutes, etc.) and in an unambiguous format acceptable to the study database like DD-MMM-YYYY. When date/time data are prepared for aggregation or sharing, they should be converted to the format specified by [ISO 8601](https://www.iso.org/iso-8601-date-and-time-format.html); YYYY-MM-DD T:hh:mm:ss. If a previously recorded AE worsens, a new record should be created with a new start date/time. There should be no AE start date prior to the date of the informed consent. Any AE that started prior to the informed consent date belongs instead in the medical history. If an item recorded on the medical history worsens during the study, the date of the worsening is entered as an AE with the start date/time as the date/time the condition worsened.
* Site AE Awareness Date – Record the date and time the site became aware of the adverse event. Record the date/time according to the [ISO 8601](https://www.iso.org/home.html), the International Standard for the representation of dates and times. The date/time should be recorded to the level of granularity known (e.g., year, year and month, complete date plus hours and minutes, etc.) and in an unambiguous format acceptable to the study database like DD-MMM-YYYY. When date/time data are prepared for aggregation or sharing, they should be converted to the format specified by [ISO 8601](https://www.iso.org/iso-8601-date-and-time-format.html); YYYY-MM-DD T:hh:mm:ss.
* Ongoing? – Choose No or Yes. If NO, record date of resolution.
* Resolution Date – Record the date (and time) the adverse event stopped or worsened. Record the date/time according to the [ISO 8601](https://www.iso.org/home.html), the International Standard for the representation of dates and times. The date/time should be recorded to the level of granularity known (e.g., year, year and month, complete date plus hours and minutes, etc.) and in an unambiguous format acceptable to the study database like DD-MMM-YYYY. When date/time data are prepared for aggregation or sharing, they should be converted to the format specified by [ISO 8601](https://www.iso.org/iso-8601-date-and-time-format.html); YYYY-MM-DD T:hh:mm:ss. If an AE worsens, record an end date/time and create a new AE record with a new start date/time and severity.
* Severity – Choose the one severity that best describes the investigator’s assessment of the intensity of the AE. The three severity grades are from the [Clinical Data Interchange Standards Consortium (CDISC) terminologies](https://www.cdisc.org/kb/ecrf/adverse-events). Severe events interrupt the participant’s normal daily activities and generally require systemic drug therapy or other treatment; they are usually incapacitating. Consequently, a change in severity may constitute a new reportable AE. Severity is not synonymous with seriousness. A severe rash is not likely to be an SAE. Likewise, a severe headache is not necessarily an SAE. However, mild chest pain may result in a day’s hospitalization and thus is an SAE. It is helpful to define the severity categories in the protocol or Manual of Operations to obtain consistency in reporting across sites.
* Investigator Assessment of Study Intervention Causality – Choose one. Record the investigator’s assessment as to whether there is at least a reasonable possibility that the AE is related to (or caused by) use of the study intervention. Definitions for each of the relatedness response should be supplied in the protocol. Permissible values included are from [NCI Guidelines: Adverse Event Reporting Requirements](https://ctep.cancer.gov/protocolDevelopment/electronic_applications/docs/aeguidelines.pdf):

Unrelated to investigational agent/intervention

Unrelated – The AE *is clearly* ***NOT*** *related* to the intervention

Unlikely – The AE *is* ***doubtfully related*** to the intervention

Related to investigational agent/intervention

Possible – The AE ***may be related*** to the intervention

Probably – The AE ***is likely related*** to the intervention

Definite – The AE ***is clearly related*** to the intervention

* Action Taken with Study Intervention – Choose one. This CDE is only appropriate for clinical trials and should be removed from the CRF if a study does not have an intervention.
* Other Action Taken – Choose one. If non-study medical treatment was required, then the corresponding medication(s) needs to be recorded on the Prior and Concomitant Medications CRF. If non-study interventions other than medications were required, they need to be documented on the appropriate study-specific CRF.
* Outcome Attributed to the Event – Choose one. The outcome of an AE may not be captured at the visit during which it was first reported but must be captured to provide a complete picture of the event. Entering the outcome of an AE may be deferred until the AE is resolved, or the participant completes the study. For AEs that have not resolved at the time of a study visit, the outcome should be marked as “Not recovered/Not resolved” on the AE CRF.
* Serious Adverse Event? – Choose either No or Yes. This question should only be answered YES if the outcome of the AE results in at least one of the following: death; a life-threatening experience; inpatient hospitalization; prolongation of existing hospitalization; a persistent or significant disability or incapacity; a congenital anomaly/birth defect; or an Important Medical Event. If an AE is serious, this provides a trigger that additional information must be provided by the site investigator. The site investigator then completes a Serious Adverse Event (SAE) form. Additionally, the site institution and/or IRB may also have an SAE form and procedures for reporting SAEs.
* Unexpected Adverse Event? – Choose No or Yes. This question should be answered YES if the AE was not previously identified as an adverse event associated with use of the investigational drug or medical device, based on those described in the Investigator’s Brochure. An event may also be identified as unexpected if the adverse event increased in frequency or severity than what is described by the Investigator’s Brochure.
1. Serious: Yes should be answered to identify an adverse event defined by the investigator or sponsor as serious because it is life-threatening, results in death, requires in-patient hospitalization, prolongs existing hospitalization, results in persistent or significant disability, is a congenital anomaly/birth defect or is an important medical event. [↑](#footnote-ref-1)
2. Unexpected: Yes should be answered to identify an adverse event that was not expected, based on those described in the Investigator’s Brochure for use of the investigational drug or medical device. An adverse event is categorized by the sponsor as “unexpected” because the adverse event has not been previously described in the Investigator’s Brochure or has increased in frequency or severity compared to what is described by the Investigator’s Brochure. [↑](#footnote-ref-2)
3. No: Not needed now because was not serious but will be reported at annual review; Yes: Required if serious. [↑](#footnote-ref-3)