(sending institution: please stamp here):

phone: (__________) __________ - __________ extensions please

patient label
name, date of birth, address

GHSG Studienzentrale
Uniklinik Köln

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Germany

phone: + 49 221 / 478 -88166
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FINAL REPORT FR

Trial: **AVD-Rev**

Case ID: **CRF ID:**

DATE OF DEATH

day month year

CAUSE OF DEATH
(please specifiy below)

- ☐ tumor-related
- ☐ therapy-related
- ☐ secondary malignancy
- ☐ accident
- ☐ suicide
- ☐ other

AUTOPSY performed: ☐ **no**

☐ **yes, on** day month year

result:

tumor: ☐ not found ☐ found in: __________

(If autopsy performed, please send a copy of findings!)

Did the patient have a SECONDARY MALIGNANCY?: ☐ **no**

☐ **yes:** ☐ Leukemia, MDS ☐ NHL ☐ Solid Tumor

date of diagnosis

(If yes, please specify below and submit report)

Please describe the cause of death in detail (please submit the last medical report):

day month year

Investigator signature