PRESTO TRIAL: 2 WEEK TREATMENT CONFIRMATION FORM

Participant ID Number: ☐☐☐☐☐☐

Date of visit: ☐☐ / ☐☐ / ☐☐☐☐ (day / month / year) Tick here if patient did not attend visit ☐

This form is for the Research Nurse/Associate and Surgeon to complete at the 2 Week follow up assessment appointment.

If patient was initially recruited via consultee process have they provided informed consent?

*Yes ☐ No ☐ *If '**Yes**', date of consent: ☐☐ / ☐☐ / ☐☐☐☐ (day / month / year)

1. **Regardless of which treatment the patient was randomised to, please tick any of the following that the patient received for their spine injury since the Eligibility Assessment:**

Surgery 1*	☐	If so, date of surgery	☐☐ / ☐☐ / ☐☐☐☐
Surgery 2*	☐	If so, date of surgery	☐☐ / ☐☐ / ☐☐☐☐
Orthotic Brace (off the shelf)	☐	If so, date commenced	☐☐ / ☐☐ / ☐☐☐☐
		Stop date	☐☐ / ☐☐ / ☐☐☐☐
Orthotic Brace (customised)	☐	If so, date commenced	☐☐ / ☐☐ / ☐☐☐☐
		Stop date	☐☐ / ☐☐ / ☐☐☐☐
Other:	☐	If so, date commenced	☐☐ / ☐☐ / ☐☐☐☐
Specify: ☐		Stop date	☐☐ / ☐☐ / ☐☐☐☐ (day / month / year)

*Please ensure that a surgery form is completed for each surgery listed

2. **If the patient did not receive the treatment they were randomised to, please record the date of, and reason for, the decision to cross-over to the alternative treatment.**

Date: ☐☐ / ☐☐ / ☐☐☐☐ (day / month / year) Reason for cross-over: ☐ Patient Choice ☐ Surgeon Choice

Reason:

3. **For patients randomised to conservative treatment option, is fracture stabilised?** Yes ☐ *No ☐

*If '**No**', please indicate action to be taken (specify if none):

4. **For patients randomised to conservative treatment option, please list any specific instructions regarding treatment compliance given at this clinic visit?**

☐ Brace worn for 24 hours/day (except washing) ☐ Brace worn during day only

☐ Bed rest with activity allowed ☐ Other (specify):

5. **Physiotherapy received in hospital from physiotherapist/spinal CNS/Orthotist since randomisation**

Date of 1st Physiotherapy session: ☐☐ / ☐☐ / ☐☐☐☐ (*day* / *month* / *year*)

Number of sessions: ☐☐ Average duration of sessions: ☐☐☐ mins

Advice and education given *(please tick all that apply)*:

☐ Bracing ☐ Mobilisation ☐ Precautions ☐ Exercises

Date of mobilisation at the advice of the Physio: ☐☐ / ☐☐ / ☐☐☐☐ (*day* / *month* / *year*)

Walking aids given? Yes ☐ No ☐ Specify: ______

Any lasting complications?

☐ Pain ☐ Stiffness ☐ Reduced function ☐ None ☐ Other (specify): ______

Date of discharge from Physiotherapy: ☐☐ / ☐☐ / ☐☐☐☐ (*day* / *month* / *year*) ☐ Tick if not yet discharged

6. **Imaging received since treatment date** *(please tick all that apply)***:**

Date: (dd/mm/yyyy)	**x-ray (standing)**	**x-ray (sitting)**	**x-ray (supine)**	**CT scan (standing)**	**CT scan (sitting)**	**CT scan (supine)**	**MRI (supine)**
☐☐ / ☐☐ / ☐☐☐☐	☐	☐	☐	☐	☐	☐	☐
☐☐ / ☐☐ / ☐☐☐☐	☐	☐	☐	☐	☐	☐	☐
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Kyphotic angle measurement (COBB) ☐☐☐ degrees Date of imaging used in measurement: ☐☐ / ☐☐ / ☐☐☐☐ (*day* / *month* / *year*)

Kyphotic angle measured: ☐ Supine ☐ Sitting ☐ Standing

Via which imaging type: ______

7. **Date of discharge from hospital:**

☐☐ / ☐☐ / ☐☐☐☐ (*day* / *month* / *year*) ☐ Tick if not yet discharged Length of hospital stay ☐☐☐ days

Where was patient discharged to?

☐ Own home ☐ Relative's home ☐ Residential home ☐ Nursing home

☐ Other (specify): ______

Completed by (signature/date):

______ ☐☐ / ☐☐ / ☐☐☐☐ (*day* / *month* / *year*)

Thank you for completing this form which the designated person should now return to York Trials Unit in the freepost envelope provided.