A1.   Study Identification Number   ___ ___ - ___ ___ ___ ___ ___ - ___

Replaced by blinded ID

blind_id	Blinded ID
RANDOMIZ	A5. SHOULD THIS PATIENT BE RANDOMIZED

A2.   Acrostic Identifier   ___ ___ ___ ___ ___

Removed to protect privacy

A3.   Date of form completion   __ __ / __ __ / __ __ __ __
                                        M   M   D   D   Y   Y   Y   Y

Replaced by age at form completion

comp_age	A3. <created var>Age at form completion, days

A4.   Name of person completing form   ___ ___ ___
                                              INITIALS

Removed to protect privacy

A5.   **SHOULD THIS PATIENT BE RANDOMIZED?**   YES……..1   NO………2

RANDOMIZ	A5. SHOULD THIS PATIENT BE RANDOMIZED

   A5a.   If NOT, specify reason:

   _____

   _____

   _____

NORAND_S	A6. If NOT, specify reason

   ** IF RESPONSE TO A5 IS "NO" (2), THEN PATIENT WILL NOT BE RANDOMIZED**

   NOTE: THIS IS NOT A DATA COLLECTION FORM – FOR TRAINING PURPOSES ONLY