



RESCUEicp Adverse (AE) and Serious Adverse Event (SAE) form

Centre Name _____ Centre Number _____ Centre Contact _____

Patient's Name	Hospital Number	Date of Birth	Patient's Consultant

Details of AE/SAE:

Please tick appropriate: Adverse Event Serious Adverse Event

Did any of the following have direct relation to AE/SAE: Initial TBI Deterioration

Cranial Surgery Other surgery Not related

Event Name: _____ Start Date ___/___/___ End Date ___/___/___

Please provide a description of the event (including a description of event, treatment and outcome):

Outcome: Resolved Ongoing Death

Reason for Seriousness: Fatal Life Threatening Prolonging/requiring hospitalisation

Other _____

Please return the completed form to: Liz Corteen, Research Nurse (RESCUEicp)
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