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Site Number

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Subject Number

Form CE - Clinical Events**1 CE - Clinical Events**

1.1	Were any clinical events experienced?	<input type="radio"/> [N] No <input type="radio"/> [Y] Yes	CEYN										
1.2	Clinical Event		CETERM										
1.3	Start Date (DD-MMM-YYYY)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>											CESTDAT
1.4	Ongoing	<input type="radio"/> [N] No <input type="radio"/> [Y] Yes	CEONGO										
1.5	End Date (DD-MMM-YYYY)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>											CEENDAT
1.6	Severity	<input type="radio"/> [MILD] Mild <input type="radio"/> [MODERATE] Moderate <input type="radio"/> [SEVERE] Severe	CESEV										