

## **BSRBR COMPARISON COHORT SWITCH FORM**

**FOR USE WHEN PATIENTS ALREADY REGISTERED AS A COMPARISON COHORT PATIENT WITH THE BSRBR SWITCHES TO ANY BIOLOGIC DRUG**

I can confirm this patient is already registered with the BSRBR as a comparison cohort patient (please provide details)



<b>BSRBR Patient ID:</b>
<b>Patient Name:</b>
<b>Patient HRN:</b>

**I can confirm that this patient is starting a biologic drug and understand that follow up of them as a BSRBR comparison cohort patient will no longer continue**

**Please provide details of the new drug:**

Name of biologic drug:
Biologic therapy start date:

Dose/s (please also provide dates of administration):

1. Please indicate the current disease activity (i.e. at the time that this biologic agent was started):

28 tender joint count	<input type="text"/>	<input type="text"/>	<input type="text"/>
28 swollen joint count	<input type="text"/>	<input type="text"/>	<input type="text"/>
ESR <b>OR</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>
CRP	<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient global assessment (VAS)	<input type="text"/>	<input type="text"/>	<input type="text"/> mm
<b>Date of DAS:</b> ____/____/____			

2. Drug therapy - Please list all of the patient's current treatment, for any indication (i.e. at the time that the biologic agent was started)


3. Co-morbidity: Has the patient ever had (i.e. required treatment for) any of the following:

	Don't			Year of onset
	Yes	No	know	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Renal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
TB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Demyelination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Cancer <sup>‡</sup>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

<sup>‡</sup> Please provide details of cancer:

Please attach this form to the follow up questionnaire for this patient that you have received from the BSRBR, and return to us in the pre-paid envelope provided.  
Many thanks!