

CONFIDENTIAL – PROPERTY OF CFRI CLG
CFRI VARIABLE LIST – VERSION 3.1
16/09/2022

Contents

1. Enrolment form.....	5
2. Core data form	6
Demography.....	6
Patient status	6
Patient’s identity.....	6
Address.....	6
Ethnicity	6
CFRI consent.....	7
Consent & assent	7
CFRI re-consent	7
CF View consent & assent	7
Medical care.....	7
3. Diagnostic form.....	8
Diagnosis	8
New-born bloodspot screening	8
Sweat test.....	8
Nasal Potential Difference (NPD).....	8
Intestinal Current Measurement	8
CFTR Genotype.....	8
Mutation 1	8
Mutation 2	9
CF History	9
4. Transplant status form.....	10
Transplant history	10
5. For CFRI official use only	10
6. Encounter form	11
Encounter data.....	11
Encounter visit date	11
Team review history.....	11
7. Anthropometry form.....	11
8. Spirometry form.....	11
Today’s PFTs.....	11
LCI.....	11
9. Complications form.....	12

Respiratory (cardio) complications	12
Gastrointestinal (GI) complications	12
CF-related liver disease	12
Other liver disease	12
Diabetes status.....	12
Bone and joint complications	12
Other complications.....	12
10. Regular medications form.....	12
Regular pulmonary medications	12
Gastro-intestinal/Nutritional medications.....	13
CF-related Diabetes (CFRD) control medication	13
Nutritional supplements form	13
Osteoporosis/osteopenia treatment form	13
Post-transplant medication	13
CFTR Modulators.....	13
Other chronic medications.....	13
11. Microbiology form	14
Pathogens since last visit	14
Pathogens results.....	14
12. Lab investigations.....	14
Haematology	14
Full blood count	14
Coagulation	14
Biochemistry	14
Liver function tests.....	14
Miscellaneous	15
Renal function tests	15
Endocrinology	15
Glucose tolerance test	15
Haemoglobin A1C.....	15
Immunology	15
Vitamins/Minerals.....	15
Pancreatic status.....	15
Sweat test.....	15
13. Radiology form.....	15

Chest X-ray 15

HRCT Thorax..... 16

DEXA scan..... 16

Abdominal ultrasound 16

14. Acute care 16

 Acute antibiotics 16

 Acute antifungal..... 16

 Hospitalisation 16

15. Physiotherapy 17

 Airway Clearance Technique (ACT)..... 17

 Oxygen therapy..... 17

 Non-Invasive Positive Pressure Ventilation Therapy (NIV)..... 17

 Exercise/activity..... 17

 Exercise tolerance test..... 17

 VO2 (peak)..... 17

 Anaerobic threshold..... 17

 Heart rate / blood pressure / SPO2 / BORG..... 17

 MET 18

16. Pregnancy..... 18

17. Clinical trials 18

VERSION HISTORY 18

1. ENROLMENT FORM		Notes
	CFRI ID	Auto-generated number
	Date enrolled	DD/MM/YYYY. Auto-generated.
	First name	Text
	Last name	Text
	Date of birth	DD/MM/YYYY
	Sex	Male/female
	Label for patient record	Text. Auto-populated.
	Patient consented to inclusion in CFRI	Yes/No
	Date consent refused	DD/MM/YYYY
	CFRI CLG consent (& assent) form(s) signed?	Yes/Not yet
	Informed consent provided by	Self/Other
	Consenter's first name	Text
	Consenter's last name	Text
	Date of written informed consent	DD/MM/YYYY
	Date consent received by CFRI	DD/MM/YYYY
	Assent	Yes/No

2. CORE DATA FORM		Notes
2.1	Demography	
2.1.1	<i>Patient status</i>	
	Patient status	Alive/deceased/lost to follow-up/discharged from CFSPID follow-up.
	Is the patient dead?	Yes/no
	Date of death	DD/MM/YYYY
	Age of death	DD/MM/YYYY
	Cause of death	Respiratory/Cardiorespiratory Liver disease/liver Failure Other CF-related (please specify) Transplant related Trauma Suicide Cancer Non-CF related (please specify) Missing, variable not collected yet
	Place of death	
	Is the patient lost to follow-up?	Yes/no
	Date of lost to follow-up	DD/MM/YYYY. Auto-generate with date of last encounter.
	Cause of lost to follow-up	Emigrated Poor attendance Other Missing, variable not collected yet
	Has the patient been discharged?	Yes/no
	Date of discharge?	DD/MM/YYYY
2.1.2	<i>Patient's identity</i>	
	CFRI registry ID	Auto-generated
	Individual Health Identifier (IHI)	Text
	Sex	Male/female. Auto-generated from enrolment form
	Date of birth	DD/MM/YYYY. Auto-generated from enrolment form
	Previous name (if different)	Text
	Country of birth	Dropdown: all country list
2.1.3	<i>Address</i>	
	Address	Text
	City/town	Text
	County	Dropdown: all Irish county list
	Eircode	Text
2.1.4	<i>Ethnicity</i>	Dropdown: White Irish White Irish Traveller Other White Background Black Irish Black African Other Black Background Pakistani Indian Chinese Other (please specify)

2.2	CFRI consent	
2.2.1	<i>Consent & assent</i>	
	Consent form signed?	Consent given Consent refused Consent Withdrawn
	Reason for refusal	Text
	Informed consent provided by	Self/other
	Consenter's first name	Text
	Consenter's last name	Text
	Date of written informed consent	DD/MM/YYYY
	Date consent received by CFRI	DD/MM/YYYY
	Assent	Yes/no
2.2.2	<i>CFRI re-consent</i>	
	*Re-consent due-date	DD/MM/YYYY
	Re-consent form signed	Not yet Consent given
	Date of written informed re-consent	DD/MM/YYYY
	Reason for re-consent refusal	Text
	Reason for consent withdrawal	Text
2.2.3	<i>CF View consent & assent</i>	HIDDEN
	*Consent form signed?	
	Reason for refusal	
	Informed consent provided by	
	Consenter's first name	
	Consenter's last name	
	Date of written informed consent	
	Date consent received by CFRI	
	Assent	
2.3.4	<i>Medical care</i>	
	Current CF centre	Dropdown: all Irish CF centres list. Will auto-generate when patient is enrolled & change is patient is transferred.
	Medical record number (MRN)	Text
	Date chart last reviewed	DD/MM/YYYY
	Does the patient attend another hospital?	Yes/no. Auto-generated from share/transfer tab.
	Other hospital name	Auto-generated from share/transfer tab.
	Medical record number (MRN) (other hospital)	Text

3. DIAGNOSTIC FORM		Notes
3.1	Diagnosis	
	Diagnosis confirmed?	CF CFSPID CF diagnosis reversed
	Date of CF diagnosis	DD/MM/YYYY
	Age at CF diagnosis	Auto-generated
	Date of CFSPID diagnosis	DD/MM/YYYY
	Age at CFSPID diagnosis	Auto-generated
3.1.1	<i>New-born bloodspot screening</i>	
	New-born bloodspot screening	Yes Not done Unknown Performed, results positive Performed, results negative Performed, results unknown
	Date of new-born screening	DD/MM/YYYY
	IRT concentration	Numeric (up to 2 decimal places)
3..1.2	<i>Sweat test</i>	
	Sweat test taken?	Yes Not done Unknown
	Hospital sweat test performed	Dropdown: all Irish CF centres list.
	Date of sweat test	DD/MM/YYYY
	Sweat conductivity	Numeric (up to 2 decimal places)
*	Chloride concentration	Numeric (up to 2 decimal places)
	Sodium concentration	Numeric (up to 2 decimal places)
3.1.3	<i>Nasal Potential Difference (NPD)</i>	
	Trans-epithelial NPD done?	No Yes Unknown Missing, variable not collected yet
	Date of NPD test	DD/MM/YYYY
	NPD value	Numeric (up to 2 decimal places)
3.1.4	<i>Intestinal Current Measurement</i>	
	Has ICM been taken?	No Yes Unknown Missing, variable not collected yet
	Date of ICM	DD/MM/YYYY
	CF-typical ICM value	No Yes Unknown Indeterminate
3.2	CFTR Genotype	
	Has patient been genotyped?	No Yes Missing (variable not collected)
3.2.1	<i>Mutation 1</i>	
	Date of first mutation reported	DD/MM/YYYY

	*First mutation	Dropdown: ECFS CFTR2 list. If other please specify
	Poly-T tract	5T 7T 9T Other (please specify if Other) Unknown
	Polymorphic TG repeat	TG9 TG10 TG11 TG12 TG13 Other (please specify if Other) Unknown
3.2.2	<i>Mutation 2</i>	
	Date of second mutation reported	DD/MM/YYYY
	*Second mutation	Dropdown: ECFS CFTR2 list. If other please specify
	Poly-T tract	5T 7T 9T Other (please specify if Other) Unknown
	*Polymorphic TG repeat	TG9 TG10 TG11 TG12 TG13 Other (please specify if Other) Unknown
3.3	CF History	
	Diagnosis suggested by the following clinical sign/symptom(s) at first of CF work-up (select all that apply) <i>Below options will be available when symptom(s) selected</i>	Newborn screening (auto-filled from CF diagnosis) Family history Meconium ileus Sinopulmonary disease Gastrointestinal and Nutritional abnormalities Other
	Family history	Text
	Meconium ileus	Meconium Ileus managed medically Meconium Ileus needing surgery Meconium Ileus unknown if operated Other neonatal intestinal and/or bowel obstruction if Yes, please specify
	Sinopulmonary disease	Acute respiratory infection/ Persistent lower respiratory symptom Digital Clubbing Sinus Disease and/or Nasal polyps Other (please specify)
	Gastrointestinal and nutritional abnormalities	Diabetes mellitus Edema and/or hypoproteinemia/hypoalbuminemia Failure to thrive and/or malnutrition Hepato-Biliary Disease Pancreatitis (Not explained by other etiologies) Prolonged jaundice Rectal prolapse Steatorrhoea and/or abnormal stools and/or malabsorption

		Other
	Other	Prenatal Screening (CVS, Amino) CBAVD (Absent vas deferens) or related abnormalities Delayed puberty Electrolyte imbalance/dehydration Infertility/GU abnormalities Other symptom(s)

4. TRANSPLANT STATUS FORM		Notes
	Current transplant status	Not referred for transplant Referred, waiting for assessment Assessed, waiting for decision Decision made, unsuitable Decision made, on active list Patient refused to consider transplant Patient removed from transplant list Transplant
4.1	Transplant history	
	Date of transplant	DD/MM/YYYY
	Type of transplant received	Double lung Unilateral lung Heart & Lung Lobes Liver Kidney Pancreas Other (please specify)
	Comment	Text

5. FOR CFRI OFFICIAL USE ONLY		Notes
	Comments	Text

6. ENCOUNTER FORM		Notes
6.1	Encounter data	
6.1.1	<i>Encounter visit date</i>	
	Date of encounter	DD/MM/YYYY
	Type of encounter	Routine CF Review Drop-in Visit Annual Review Virtual Encounter Other type of visit (please specify)
6.1.2	<i>Team review history</i>	
	Patient seen by CF consultant (or doctor) at this visit	Yes/no
	Patient seen by CF nurse at this visit	Yes/no
	Patient seen by a dietitian/nutritionist at this visit	Yes/no
	Patient seen by a physiotherapist at this visit	Yes/no
	Patient seen by a social worker at this visit	Yes/no
	Patient seen by a psychologist at this visit	Yes/no

7. ANTHROPOMETRY FORM		Notes
	Height (cm)	Numeric (no decimals)
	Height centile, height Z-score	Auto-calculated
	Weight (kg)	Numeric (up to 1 decimal place)
	Weight centile, weight Z-score	Auto-calculated
	BMI	Auto-calculated
	BMI centile, BMI Z-score	Auto-calculated

8. SPIROMETRY FORM		Notes
8.1	Today's PFTs	<i>(If multiple tests taken, record maximum test result)</i>
	PFTs performed this encounter	Not done Unable to perform reliable test Yes
	FEV1	Numeric (up to 2 decimal places)
	FVC	Numeric (up to 2 decimal places)
	FEF 25-75%	Numeric (up to 2 decimal places)
8.2	LCI	
	LCI performed this visit	Not done Unable to perform reliable test Yes
	Date of LCI	DD/MM/YYYY
	Type of device	Ecomedics Exhalyzer D N2-Washout Ecomedics Exhalyzer SF6 (Tracer gas 4%) Innovision Innocor NDD Easyone Pro
	LCI technique	SBW MBW Unknown
	LCI value	Numeric (no decimals)

9. COMPLICATIONS FORM		Notes
		For most options in column below dropdown: Yes No Unknown
9.1	Respiratory (cardio) complications	Allergic Bronchopulmonary Aspergillosis (ABPA) treated / Allergic Bronchopulmonary Aspergillosis (ABPA) untreated / Asthma / Cardiovascular Disease (including Heart failure) / Haemoptysis – Haemoptysis other / Haemoptysis Massive haemoptysis (>240ml/day or >100 ml/day for several days) / Nasal polyp / Pneumothorax-not requiring chest drain / Pneumothorax-requiring chest drain / Sinus Disease (symptomatic) / Other respiratory related complications (please specify)
9.2	Gastrointestinal (GI) complications	Constipation/abdominal pain / Distal Intestinal Obstruction Syndrome (DIOS) / Gallbladder disease / GERD (Gastro-Oesophageal Reflux Disease) / GI Bleed Req hospital non variceal / GI Bleed Req hospital variceal / Liver enzymes elevated / Pancreatic insufficiency / Pancreatitis / Rectal prolapse / Peptic ulcer disease / Other GI related complications
9.3	CF-related liver disease	Dropdown: CF Related Liver disease-stage unspecified / CF Related Liver disease-Non-cirrhosis / CF Related Liver disease-cirrhosis without portal / Hypertension/hypersplenism / CF Related Liver disease-cirrhosis, hypertension unknown / CF Related Liver disease-cirrhosis with portal hypertension/hypersplenism / Other liver disease (please specify)
9.4	Other liver disease	Hepatitis / Wilson Disease / Bleeding disorder / other (please specify)
9.5	Diabetes status	CFRD, Diet and Insulin Control / CFRD, Diet Control Gestational diabetes / Impaired Glucose Tolerance / Type I diabetes
9.6	Bone and joint complications	Arthritis/Arthropathy / Bone fracture / Osteopenia /Osteoporosis / Scoliosis / Other bone and joints related complications (please specify)
9.7	Other complications	Anxiety disorder / cardiac arrhythmias / tumor/cancer (specify type) / chronic pain / cholesterolaemia / depression / cataract / eye disease / gall stones / hearing loss / pulmonary arterial hypertension / Hypertension with cholesterolemia / Hypertension without cholesterolemia / Kidney stone / Renal disease-GFR <50% / Renal disease-Microalbuminuria / Renal disease-Nephrolithiasis / Renal disease-Proteinuria / Renal disease-requiring dialysis / Tinnitus / Salt Loss Syndrome / Splenomegaly / other (please specify)

10. REGULAR MEDICATIONS FORM		Notes
	Have there been any changes to the regular medication(s)? (Select all that apply)	Regular Pulmonary Medication / Gastro-intestinal/Nutrition Medication / CF related Diabetes (CFRD) Control Medication / Nutrition supplement / Osteoporosis/Osteopenia treatment medication / Post-Transplant Medication / Other regular medications
10.1	Regular pulmonary medications	If yes:
	Maintenance antibiotics Maintenance antifungal Bronchodilator	If yes, please indicate: Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date

	Mucolytic Corticosteroid Maintenance Nasal Preparation	
10.2	Gastro-intestinal/Nutritional medications	If yes:
	Pancreatic Enzyme Replacement Therapy H2 Blockers Proton Pump Inhibitors (PPIs) Other Antacids Vitamins/minerals Appetite stimulants CFLD medication DIOS/Constipation medication	If yes, please indicate: Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date
10.3	CF-related Diabetes (CFRD) control medication	
	Hypoglycaemic agent Insulin	If yes, please indicate: Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date
10.4	Nutritional supplements form	
	Feeding route	Oral Nutritional Supplement (ONS) / Nasogastric tube (NG tube) / Gastrostomy tube/button (G-Tube)
	Feeding regime	If yes, please indicate: Textbox: input regime name Indicate: Bolus (yes/no) / start date / continuing / stop date
10.5	Osteoporosis/osteopenia treatment form	
	Bisphosphonates Other osteoporosis/osteopenia	If yes, please indicate: Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date
10.6	Post-transplant medication	
	If yes, please indicate:	Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date
10.7	CFTR Modulators	
	If yes, please indicate:	Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date / reason ended
	Reason ended:	Dropdown: Non-compliance Required prohibited medication Pregnancy Withdrawal of consent Physical decision Switch to another drug Lack of efficacy Other (please specify) AE/ Intolerance (please specify)
	Date of pre-initialisation sweat test	DD/MM/YYYY
	Chloride concentration	Numeric
10.8	Other chronic medications	Notes
	Antidepressants Anti-Hypertensive medication NSAID Anti-inflammatory Drug Miscellaneous medication	Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date

* Route options: PO, via NG, Intravenous (IV), Inhaled, Nebulised, nasal spray, via PEG, other route (please specify), subcutaneous, intramuscular

11. MICROBIOLOGY FORM		Notes
11.1	Pathogens since last visit	
	Was a sample attempted	Yes/no
11.2	Pathogens results	
	Culture result	Culture positive Culture negative Insufficient specimen/contaminated
	Date of specimen	DD/MM/YYYY
	Specimen type (type & autofill)	Axial swab BAL Cough swab Groin swab Nasal swab Other Sample Throat swab Not Specified Sputum Culture Unknown
	Microorganism found	Dropdown: All culture types, including insufficient specimen, no growth, contaminated, culture negative options

12. LAB INVESTIGATIONS		Notes	
	Please select appropriate lab annual assessment tests (select all that apply)	Haematology Biochemistry Endocrinology Immunology Vitamins/Minerals Pancreatic status	
Haematology	12.1	<i>Full blood count</i>	
		Date of collection, WBC Haemoglobin (Hb) EOS	DD/MM/YYYY Numeric Numeric Numeric
	12.2	<i>Coagulation</i>	
		Date of collection Prothrombin time INR APTT	DD/MM/YYYY Numeric Numeric Numeric
Biochemistry	12.3	<i>Liver function tests</i>	
		Date of collection Total protein Serum albumin Total bilirubin Alk phos Gamma GT ALT AST	DD/MM/YYYY Numeric Numeric Numeric Numeric Numeric Numeric Numeric

	12.4	<i>Miscellaneous</i>	
		Date of collection Serum amylase Ferritin	DD/MM/YYYY Numeric Numeric
	12.5	<i>Renal function tests</i>	
		Urea Serum creatinine	Numeric Numeric
Endocrinology	12.6	<i>Glucose tolerance test</i>	
		Date of collection Fasting glucose 30 min glucose 60 min glucose 90 min glucose 2 hr PP glucose	DD/MM/YYYY Numeric Numeric Numeric Numeric Numeric
	12.7	<i>Haemoglobin A1C</i>	
		Date of collect HbA1c (IFCC)	DD/MM/YYYY Numeric
	12.8	<i>Immunology</i>	
		Date of collection IgA IgG IgM IgE IgE Rast Aspergillus titre Aspergillus Fumigatus Ab	DD/MM/YYYY Numeric Numeric Numeric Numeric Numeric Numeric
	12.9	<i>Vitamins/Minerals</i>	
		Date of collection Vitamin A Vitamin D (1,25-Dihydroxy-vitamin D serum) Vitamin E	DD/MM/YYYY Numeric Numeric Numeric
	12.10	<i>Pancreatic status</i>	
		Date of collection Faecal elastase Faecal fat	DD/MM/YYYY Numeric Numeric
	12.11	<i>Sweat test</i>	
		Date of collection Chloride concentration	DD/MM/YYYY Numeric

13. RADIOLOGY FORM		Notes
	Please select appropriate lab annual assessment radiology (select all that apply)	Chest X-Ray HRCT Thorax DEXA scan Abdominal ultrasound
13.1	Chest X-ray	If selected

	Date performed Check X-ray report (required for CFSPID)	DD/MM/YYYY Textbox
13.2	HRCT Thorax	If selected
	Chest CT scan report date CT scan report (required for CFSPID) CT scoring system used CT score	DD/MM/YYYY Textbox Brody, Pragma, Other (please specify) Textbox
13.3	DEXA scan	If selected
	Date performed Femur T-Score Femur Z-Score Lumbar spine T-Score Lumbar spine Z-Score DEXA conclusion	DD/MM/YYYY Numeric Numeric Numeric Numeric Normal bone density Lower bone mass / Osteopenia (T-score 1.5 to -2.49) / Osteoporosis (T-score -2.5 or less)
13.4	Abdominal ultrasound	If selected
	Date of performed Abdominal U/S indication	DD/MM/YYYY Normal Increased heterogeneity Fatty Liver Splenomegaly Cirrhosis Portal hypertension Varices Gallstones

14. ACUTE CARE		Notes
14.1	Acute antibiotics	
	Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date	
	Indication	Exacerbation of RTI Exacerbation therapy Other (please specify)
14.2	Acute antifungal	
	Dropdown: generic drug name lists Indicate: Route* / start date / continuing / stop date	
	Indication	Exacerbation of RTI Exacerbation therapy Other (please specify)
14.3	Hospitalisation	
	Admission date Continuing Discharge date	DD/MM/YYYY Tick box DD/MM/YYYY
	Reason for admission	Elective Admission for IV therapy Elective surgery CF related-Haemoptysis CF related-Pneumothorax

		CF related-DIOBs Pulmonary Exacerbation CF related-End Stage Lung Disease Transplant related Other CF related (please specify)
	In ICU ICU start date ICU end date	Yes/No DD/MM/YYYY DD/MM/YYYY

15. PHYSIOTHERAPY		Notes
	Record the physiotherapy the patient reports receiving (select all that apply)	Airway Clearance Technique (ACT) Oxygen therapy Non-Invasive Positive Pressure Ventilation Therapy (NIV) Exercise/Activity Exercise Tolerance Test
15.1	Airway Clearance Technique (ACT)	If selected
	ACT modalities	Dropdown (if other, please specify)
15.2	Oxygen therapy	If selected
	Does the patient use portable oxygen device? Home oxygen therapy Oxygen therapy modalities	Yes/no/unknown Yes/no/unknown Dropdown: overnight, ambulation, continuous, other (please specify)
15.3	Non-Invasive Positive Pressure Ventilation Therapy (NIV)	If selected
	Does the patient use Bi-level Positive Airway Pressure (BiPAP) modality for NIV IPAP EPAP Does the patient use CPAP modality for NIV	Yes/no/unknown Numeric Numeric Yes/no
15.4	Exercise/activity	If selected
	Exercise/Activity Name Frequency Duration (minutes)	Type I (Vigorous >6 MET, Type II (Moderate 3-6 MET), Type III (Light < 3 MET) Dropdown: activity list 1-3 times/week, 3-5 times/week, >5 times/week, Daily, Unknown Textbox
15.5	Exercise tolerance test	If selected
	Type of Exercise Test	Cardiopulmonary Exercise Test Modified Shuffle Walk Test Three-Minute Step Test Six-Minute Walk Test
	Testing protocol	Cycle Ergometer Treadmill
	Ramp	Numeric
	Supplemental oxygen requirement if yes, please specify flow	Yes/No Numeric
15.5.1	<i>VO₂ (peak)</i>	VO ₂ (Peak) VO ₂ (Peak) % predict
15.5.2	<i>Anaerobic threshold</i>	Anaerobic threshold Anaerobic threshold % predict
15.5.3	<i>Heart rate / blood pressure / SPO₂ / BORG</i>	Pre-Test (Rest) During Test (Max) Post-Test

15.5.4	MET	Pre-Test (Rest) During Test (Max) Post-Test Max minute ventilation (MMV) Ventilation (max exercise) Breathing Reserve Respiratory exchange ratio Oxygen-pulse (O ₂ /HR) PETCO ₂ EqCO ₂ EqO ₂ Distance walked during test Steps taken during test
--------	-----	--

16. PREGNANCY		Notes
	Please indicate if the patient is current pregnant	Yes/no/unknown
	Please indicate if the patient's pregnancy outcome is a live birth	Yes/no

17. CLINICAL TRIALS		Notes
	Please indicate if the patient is currently participating in a clinical trial	Yes/no/unknown
	Clinical trial number/code	Textbox
	Start date	DD/MM/YYYY
	Stop date	DD/MM/YYYY

VERSION HISTORY

Version	Date updated	Updates made
V2	n/a	Original 2019 document
V3	26/07/2022	Fully reviewed based on implementation of new system
V3.1	16/09/2022	Addition of sweat chloride test information (CFTRm & lab investigations)