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# PRO CoMiDa Form

# Patient Reported Outcome (PRO) Completion and Missing Data (CoMiDa) Form

# The PRO CoMiDa Form

The PRO CoMiDa Form is a data management tool, designed to provide standardised documentation of the completion or reasons for non-completion of PRO assessments by patients in a clinical trial/study. Such documentation is crucial for quality assurance since missing data are the greatest threat to the integrity and interpretability of PRO data.

The Form should be completed by the Data Manager, Research Nurse, or equivalent – whoever is responsible for QOL data collection. This person may be located at the site where QOL data is collected (e.g. at clinic), or centralised (e.g. when QOL assessments are completed at home), and will depend on each individual study.

# Using the PRO CoMiDa Form Template

The template provided on the next page may be adapted to specific clinical trials/studies. The QOL Office is able to assist members of the National Cancer Clinical Trials Groups with this if needed.

The PRO CoMiDa Form may be adapted in the following ways:

1. pasting the content of the form onto a trial/study letterhead
2. inserting the specific clinical trial/study details
3. adapting the reasons for missing data to suit the likely applicable reasons for the given clinical trial/study
4. inserting the names of specific PRO measures used in the clinical trial/study
5. inserting the relevant contact details of the clinical trial manager or project coordinator
6. inserting the relevant return advice for the clinical trial/study

If you have any queries about the PRO CoMiDa Form, please contact [qol.office@sydney.edu.au](mailto:qol.office@sydney.edu.au)

When you finalise a PRO CoMiDa Form for a study, we would be grateful if you would forward a copy to the QOL Office for our private records so we can learn more about the formatting that you prefer and the circumstances in which PRO data are collected in your trials.

Version 2, updated 6 September 2012

# <Insert name of trial/study> PRO CoMiDa Form

**Today’s date**: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ **Site name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Site number**:\_\_\_\_\_\_\_\_\_\_\_\_

**Patient ID**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient’s Initials:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Patient’s date of birth:** \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**Select the current PRO Assessment Timepoint: *(NOTE: You may omit this item and create a CoMiDa Form for each timepoint)***

Baseline  Cycle 2 Cycle 3  Cycle 4  Cycle 5

End Treatment (EOT)  1 mth post-EOT  3 mth post-EOT  1 yr post-EOT  3 yr post-EOT

1. **Were the following PRO forms completed at this scheduled assessment?**Please complete each box below with one of the following codes: **1** = Yes, **2**= NA (not required at this timepoint), **3** = No

⬜*<Insert name of PRO form/questionnaire here*>, required at timepoint(s) <*insert timepoint(s) as per assessment schedule for this questionnaire here* >

⬜<*Insert name of PRO form/questionnaire here*>, required at timepoint(s) <*insert timepoint(s) as per assessment schedule for this questionnaire here* >

⬜<*Add additional rows if required>*

1. **Did the patient require any assistance in completing the questionnaire?**

No

Yes. Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **How were the questionnaires administered?**

At clinic  By telephone  Online  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What language were the questionnaires completed in?**

English  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If the patient completed ALL questionnaires required for this scheduled assessment, you have completed this form. If any questionnaires were MISSED (i.e. if you answered ‘3’ to any of the questionnaires in question 1 above), please continue.*

1. **Please select the most appropriate reason for non-completion of the questionnaire(s).**

Patient received the questionnaire/s, but did not return them

Patient refused to complete questionnaire

Unable to contact patient

Patient missed appointment of scheduled assessment

Patient withdrew from study

Institution forgot to administer questionnaire

Institution administered incorrect questionnaire

Online questionnaire malfunction

Patient has passed away (tick ‘Yes’ for Q6)

Other. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Is the reason for non-completiong (as stated above) related to the patient’s illness?**

Yes

No

Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed the PRO CoMiDa Form and PRO Forms. All forms are complete or an explanation is given for any missing data.

**Person completing this form:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_

**Return instructions:**

<Insert name & address of Clinical Trial Manager/ study contact person>

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**Today’s date**: \_23\_/\_10\_/\_2011\_ **Site name**:\_RPA\_\_\_\_\_ **Site number**:\_\_\_1\_\_\_\_ **Clinician**: Dr Bob

**Patient ID**:\_12\_\_\_\_\_ **Patient’s Initials:** \_\_PK\_\_\_\_\_\_ **Patient’s date of birth:** \_4\_/\_5\_\_/\_1948\_\_

**Select the current PRO Assessment Timepoint:**

Baseline  Cycle 2 Cycle 3  End Treatment (EOT)  6 mths post-EOT

1 yr post-EOT  3 yr post-EOT  5yr post-EOT

1. **Were the following PRO forms completed at this scheduled assessment?**Please complete each box below with one of the following codes: **1** = Yes, **2**= NA (not required at this timepoint), **3** = No

3  **FACT-O** required at **ALL** timepoint(s)

2  **SF-36** required at **BASELINE ONLY**

1  **Symptom Representation Questionnaire** required at **ALL** timepoint(s)

1. **Did the patient require any assistance in completing the questionnaire?**

No

Yes. Please describe: Patient’s husband read questions to patient and filled in the form with patient’s responses

1. **How were the questionnaires administered?**

At clinic  By telephone  Online  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **What language were the questionnaires completed in?**

English  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If the patient completed ALL questionnaires required for this scheduled assessment, you have completed this form. If any questionnaires were MISSED (i.e. if you answered ‘3’ to any of the questionnaires in question 1 above), please continue.*

1. **Please select the most appropriate reason for non-completion of the questionnaire(s).**

Patient received the questionnaire/s, but did not return them

Patient refused to complete questionnaire

Unable to contact patient

Patient missed appointment of scheduled assessment

Patient withdrew from study

Institution forgot to administer questionnaire

Institution administered incorrect questionnaire

Patient has passed away (tick ‘Yes’ for Q6)

Other. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Is the reason for non-completing (as stated above) related to the patient’s illness?**

Yes

No

Notes: Patient felt too tired to complete the final questionnaire in the battery (FACT-O)

I have reviewed the PRO CoMiDa Form and PRO Forms. All forms are complete or an explanation is given for any missing data.

**Person completing this form:**

Name: Jane Jones Signature: JJones Date: 23/10/2011

**Return instructions:**

Return this form as soon as possible by attaching it to an email with scans of the patient’s QOL Forms.

Attention: Professor Zachary Smith

Email:zsmith@uni.com