SCREENING VISIT CHECKLIST

INFORMATION ABOUT THE SCREENING VISIT

Site Name: _____

Address: _____

Staff Contact Name: _____ Phone: _____ Email: _____

Appointment Time: _____ Room/Building Number: _____

Accessible Parking Available? Yes ☐ No ☐

Planned Procedures and Tests: _____

Required Information to Verify Trial Eligibility*: _____

Notes: _____

**For example, these may include documentation of SMN2 copy number or recent hospitalizations.*

INFORMATION ABOUT ME/MY FAMILY MEMBER:

This section may be completed before the screening visit to enhance discussions with members of the research team. Please include all medications, treatments, and hospitalizations, including those unrelated to SMA.

SMA Type: _____ SMN2 Copy Number: _____

Study team requires documentation of SMN2 copy number? Yes ☐ No ☐

Current maximum motor function: ☐ Sit with support ☐ Sit without support ☐ Able to stand ☐ Able to walk

Diagnostic history:

Check if prenatal diagnosis: ☐

Check if diagnosed through Newborn Screening: ☐

Age at which SMA symptoms began (in months): _____ Diagnosis date: _____

Recent vaccine history (*last 12 months*):

Date: _____ Vaccine: _____ Date: _____ Vaccine: _____

Date: _____ Vaccine: _____ Date: _____ Vaccine: _____

Date: _____ Vaccine: _____ Date: _____ Vaccine: _____

Recent hospitalization history
(*last 12 months; please include hospitalizations related to receiving SMA treatment*):

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Date: _____ Reason for hospitalization: _____

Recent illness history (*last 12 months*):

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Start Date: _____ End Date: _____ Illness: _____ Medications Taken: _____

Recent injury history (*last 12 months*):

Date: _____ Injury: _____ Treatment(s) Taken: _____

Date: _____ Injury: _____ Treatment(s) Taken: _____

Date: _____ Injury: _____ Treatment(s) Taken: _____

Date: _____ Injury: _____ Treatment(s) Taken: _____

Date: _____ Injury: _____ Treatment(s) Taken: _____

Medication History (*including supplements*):

Start Date: ________ End Date: ________ Medication Name: ____________________ Dose: ___________
Reason for Taking Medication: ________________________ Reason for Stopping: ______________________________

Start Date: ________ End Date: ________ Medication Name: ____________________ Dose: ___________
Reason for Taking Medication: ________________________ Reason for Stopping: ______________________________

Start Date: ________ End Date: ________ Medication Name: ____________________ Dose: ___________
Reason for Taking Medication: ________________________ Reason for Stopping: ______________________________

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Reason for Taking Medication: ________________________ Reason for Stopping: ______________________________

Start Date: ________ End Date: ________ Medication Name: ____________________ Dose: ___________
Reason for Taking Medication: ________________________ Reason for Stopping: ______________________________

Start Date: ________ End Date: ________ Medication Name: ____________________ Dose: ___________
Reason for Taking Medication: ________________________ Reason for Stopping: ______________________________

TIP: Take a picture of each medication's packaging to help with remembering.

Physical Therapy History:

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Occupational Therapy History:

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Other Therapy History:

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Start Date: _____ End Date: _____ Type: _____ Location of Office/Clinic: _____

Reason for Stopping: _____

Surgical History:

Date of Surgery: _____ Surgery Type: _____

Date of Surgery: _____ Surgery Type: _____

Date of Surgery: _____ Surgery Type: _____

Date of Surgery: _____ Surgery Type: _____

Date of Surgery: _____ Surgery Type: _____

Planned Surgeries (*in next 24 months*):

Est. Date: _____ Surgery Type: _____

Est. Date: _____ Surgery Type: _____

Additional Health History:

Other Conditions (ex. Scoliosis, contractures, GERD, etc.):

_____

_____

_____

Known Allergens: _____

_____

Supplemental breathing devices used (ex. BiPap): _____ Hours per Day: _____

Do you use a cough assist machine? Yes ☐ No ☐ Type: _____

Feeding Routine (check all that apply): ☐ nothing by mouth ☐ tube dependent

☐ total oral diet with some compensations ☐ total oral diet with no restritctions.

Reproductive Health:

Are you currently pregnant? Yes ☐ No ☐

Are you planning on becoming pregnant in the next 24 months? Yes ☐ No ☐

Are you currently using birth control? Yes ☐ No ☐ Type: _____

Current Healthcare Providers:

Name: _____ Provider Type: _____ Phone: _____

Name: _____ Provider Type: _____ Phone: _____

Name: _____ Provider Type: _____ Phone: _____

Name: _____ Provider Type: _____ Phone: _____

Name: _____ Provider Type: _____ Phone: _____

Name: _____ Provider Type: _____ Phone: _____

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Name: _____ Provider Type: _____ Phone: _____

Name: _____ Provider Type: _____ Phone: _____

QUESTIONS TO ASK

What is the purpose of this trial?

Will I/my family member be able to continue my/their current treatment(s)?

Will my/my family member's treatment plan change?

Is there a chance of receiving a placebo or sham?

What types of medical tests and procedures will the study team perform during the trial?

How will the study team ensure me/my family member's safety and comfort during procedures?

How long am I expected to be in the clinical trial for?

How often will I have to visit the hospital or clinic? Will any of these visits require an overnight stay? Will all the visits be done in-person or is there an opportunity to do them via telemedicine?

What are the possible risks of participation?

What are the possible benefits of participation?

Who will oversee my/my family member's medical care while participating in the trial?

Who will pay the costs associated with participation?

Will I/my family member be reimbursed for other expenses? Is travel support included?

What happens if I/my family member are injured or get sick because of participation in the study?

Who else has access to my data and/or samples?