STATICH
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URL: www.statich.no

Patient no.: |__|__|__|__|__|

Scan Transfer Form

Please send one form per CD. Each CD should include all Imaging Studies performed per patient.

1. Patient information

Centre/hospital name		*or:*	Centre no.	|__|__|__|
Patient name		Date of birth	____ /____ /____	dd/mm/yy

2. Information about Imaging Studies on this CD

Please note that we want to receive raw data from all CT Imaging Studies!

Imaging Study performed at baseline (before randomisation)							
	Yes	No	*If yes:*				
MRI	☐	☐	Date	___ /___ /___	dd/mm/yy	Raw data? _______	yes/no
CT	☐	☐	Date	___ /___ /___		Raw data? _______	yes/no
	☐	☐	Date	___ /___ /___		Raw data? _______	yes/no
(Other: _______________)	☐	☐	Date	___ /___ /___			
Imaging Study performed on 2 years (i.e. 24±1 months after randomisation)							
	Yes	No	*If yes:*				
MRI	☐	☐	Date	___ /___ /___	dd/mm/yy	Raw data? _______	yes/no
CT	☐	☐	Date	___ /___ /___		Raw data? _______	yes/no
(Other: _______________)	☐	☐	Date	___ /___ /___		Raw data? _______	yes/no
Imaging Studies performed at other times (please specify):							
1.			Date	___ /___ /___	dd/mm/yy	Extra information	
2.			Date	___ /___ /___			
3.			Date	___ /___ /___			

3. Transferral of the Imaging Studies to Trial Coordinating Centre

Please send CD via postal mail to: STATICH Co-ordinating Centre, Oslo University Hospital, Ullevål, Dept. of Geriatric Medicine, Building 20, 4th floor, P.O. Box 4950 Nydalen, NO_0424 Oslo, Norway	Yes ☐ No ☐

4. Information about person sending the CD and filling out the Scan Transfer Form

Name (capital letters)	Signature
Tel. number +	E-mail address

In case of questions, please contact: Kristin T. Larsen, tel. no.: +47 22119911, e-mail: k.t.larsen@medisin.uio.no