CHILDHOOD ADENOTONSILLECTOMY STUDY
Unblinding of Participant

Participant ID: __ __ __ __ __ __
Participant Initials: __ __ __
Site: __ __
Date: __ __ / __ __ / __ __ __ __
RC ID: __ __ - __ __

Research Coordinator completes this form if the participant needs to be unblinded. Photocopies of this form with signatures must be faxed to the DCC.

1. Date participant was unblinded: ubl1

__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

2. What was the participant's randomization arm? ubl2

☐1 Early Adenotonsillectomy (EAT)
☐2 Watchful Waiting with Supportive Care (WWSC)

3. Why was the participant unblinded? ubl3

☐1 Neuropsychological scores fell outside the accepted range
☐2 Participant experienced an SAE related to medical intervention
☐3 Parent or child inadvertently disclosed their treatment arm
☐98 Other, specify: _____
_____
_____

4. Was the DCC contacted within 24 hours of unblinding?

☐0 No
☐1 Yes

4a. If ***YES***, name of the person contacted: _____

4b. If ***NO***, state the reason why: _____

PI Signature: _____ Date: __ __ / __ __ / __ __ __ __
M M D D Y Y Y Y
ubl_pidate

Directions: Fax this form to the DCC at (215) 573-6262