AE Flow Sheets
CC003

Patient Name:_____ **Patient ID:**_____

Cycle:_____

Date of Evaluation:_____

AE's To Be Evaluated Each Cycle	**GRADE**	**ATTRIBUTION** 1-unrelated, 2-unlikely, 3-possible 4-probable, 5-definite
Alopecia	0 1 2 3 4 5	1 2 3 4 5
Dry mouth	0 1 2 3 4 5	1 2 3 4 5
Dysgeusia	0 1 2 3 4 5	1 2 3 4 5
Scalp pain, redness or irritation	0 1 2 3 4 5	1 2 3 4 5
Concentration impairment	0 1 2 3 4 5	1 2 3 4 5
Memory impairment	0 1 2 3 4 5	1 2 3 4 5
Fatigue	0 1 2 3 4 5	1 2 3 4 5
Seizures	0 1 2 3 4 5	1 2 3 4 5
Hearing impairment	0 1 2 3 4 5	1 2 3 4 5
Hypersomnia	0 1 2 3 4 5	1 2 3 4 5
Cataracts	0 1 2 3 4 5	1 2 3 4 5
Nausea	0 1 2 3 4 5	1 2 3 4 5
Vomiting	0 1 2 3 4 5	1 2 3 4 5
Headaches	0 1 2 3 4 5	1 2 3 4 5
Other Adverse Events?	**Yes No**	**If yes, specify below.**
ADVERSE EVENT CTCAE Version 5.0 Unless Otherwise Stated	**GRADE**	**ATTRIBUTION**
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5
	0 1 2 3 4 5	1 2 3 4 5

PERFORMANCE STATUS: 0 1 2 3 4

INVESTIGATOR SIGNATURE:_____ **DATE:**_____