# On Study Visit Checklist – Sample

**STUDY NAME**

**Site Name:**

**Pt\_ID:**

**Visit Date:**

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**Visit Name:**  Wk1  Wk2  Wk4  Wk8  Wk12…..etc.

1. Did the participant attend this visit?  Yes (if yes, continue)  No
2. Please check all assessments completed at this visit:

 Blood Draw  Fasting  Not fasting

 Study Questionnaires  Completed by participant  Completed by staff

 Vital Signs

 Physical Exam

 Concomitant Medications

  No change

  Change from last visit (explain in Comments and record on adverse event (AE) log/case report form (CRF)

 Signs and Symptoms

  No change

  Change from last visit (explain in Comments and record on AE log/CRF)

 If this was an AE, was it serious?  Yes  No

If yes, what was the date it was reported to the institutional review board (IRB)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other (specify in Comments)

1. Is the participant continuing in the study?  Yes  No

If no, remember to complete a STUDY COMPLETION form.

If yes, schedule next visit.

Comments:

Signature: Date: