TEEN-BESTrial – Unblinding Request Report Form

Details Request

Code participating centre: _____

Applicant's name: _____

Applicant's function: _____

Applicant's phone number: _____

Date and time of the request: ____ / ____ / _____   _____:_____

Reason for the request: _____

_____

_____

_____

_____

Details patient

Name: _____

Trial number: _____

Applicants signature: _____

Request received by:

Name: _____

Function: _____

Result of request:

Request granted: Yes* / No**

Randomisation code: _____

Bariatric procedure: _____

Signature PI: _____