PATIENT SUMMARY CONTACT FORM

Trial ID : | | | | | | | | |

CBE-8

Patient Name:_____

HC Code : _____

Sr. No.	Date	Type of Contact	Reason for Contact	Duration of contact (including sessions) (minutes)	*Session Number	AUDIT / Drinking Status	PHQ-9	If Home Visit				*Refferals	*SO involvement	If Yes (SO present), relationship	Outcome
								Total time taken for home visit (minutes)	Total distance travelled in kms.	Actual cost of travel (hired transport)	**For Home Visit, number of other patients visited				

*** If applicable** ****Includes unsuccessful home visits**