

# Cirted

Combined Immunosuppression and Radiotherapy in Thyroid Eye Disease Trial

## Trial Checklist

Only tick the 'yes' box if you think the sign/symptom is due to THYROID EYE DISEASE

	Yes (even if mild)	No
1. Increase in proptosis	<input type="checkbox"/>	<input type="checkbox"/>
2. Recent onset/worsening diplopia	<input type="checkbox"/>	<input type="checkbox"/>
3. Discomfort behind eye	<input type="checkbox"/>	<input type="checkbox"/>
4. Discomfort on eye movement	<input type="checkbox"/>	<input type="checkbox"/>
5. Conjunctival redness	<input type="checkbox"/>	<input type="checkbox"/>
6. Subconjunctival fluid (chemosis)	<input type="checkbox"/>	<input type="checkbox"/>
7. Eyelid swelling	<input type="checkbox"/>	<input type="checkbox"/>

If you have ticked 2 or more 'YES' boxes, please continue

8. Young (<20yrs) or Old (>75yrs)	<input type="checkbox"/>	<input type="checkbox"/>
9. Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes Mellitus (excluding steroid induced)	<input type="checkbox"/>	<input type="checkbox"/>
11. Dysthyroid Optic Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>

If all of the answers to the last 4 questions are 'NO' please ask the patient if they are happy to be referred for further assessment to see if they are eligible to take part in a clinical trial of treatments in Thyroid Eye Disease and inform us of their name and contact details (address, phone number, email).

See contact details to refer to your local trial centre.

Patient name: _____	Address (please place patient sticker or print below) <div style="border: 1px solid black; height: 150px; width: 100%;"></div>
Telephone: _____	
Email: _____	