

Tri-Solfen®

Off-label use in horses Questionnaire for veterinarians

Completion of this form is requested to document the safety and efficacy of the product when used on open wounds of horses.

Name of treating veterinarian: _____

Clinic name: _____ **Telephone:** _____

Owners name: _____ **Address:** _____

Veterinarian approval (signature): _____

Horse details

Animal name/ identification: _____ **Breed:** _____

Weight: _____ **Age:** _____

<p>Wound details</p> <p>Date of injury: _____ Wound Location: _____</p> <p>Size (est): _____ cm² Appearance: _____</p> <p>Cause: _____</p>	<p>Other medications?</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p>Bandaging Yes No</p> <p>Debriding Yes No</p> <p>Suturing Yes No</p> <p>Other <div style="border: 1px solid black; width: 100%; height: 20px;"></div></p>
	<p>Previous or additional treatment? Yes No</p> <p><i>If yes please document in the box on the right.</i></p>
<p>Wound diagram or photographs Please photograph wound if possible and email to us (see page 4). Photographs: Yes No</p>	<p>Wound diagram: Please include a sketch here or attach one on a separate sheet, with wound dimensions</p> <div style="border: 1px solid black; height: 150px; width: 100%;"></div>

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<p>Treatment details</p> <p>Initial treatment</p> <p>Date: <input type="text"/> Time: <input type="text"/></p> <p>Vol of Tri-Solfen® applied: <input type="text"/> ml</p> <p>Batch number: <input type="text"/></p> <p>Adverse reaction</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Observations or comments:</p> <hr/> <hr/> <hr/> <p>Adverse reaction details:</p> <hr/> <hr/> <hr/>
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<p>Repeat treatments</p> <p>Repeat treatment number:</p> <table border="1"> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </table> <p>Date:</p> <table border="1"> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </table> <p>Time:</p> <table border="1"> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </table> <p>Batch number:</p> <table border="1"> <tr> <td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td><td><input type="text"/></td> </tr> </table> <p>Volume applied:</p> <table border="1"> <tr> <td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td><td><input type="text"/> ml</td> </tr> </table> <p>Adverse reaction:</p> <p>Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N Y N</p>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml	<input type="text"/> ml
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<p>Adverse reactions</p> <p>Batch number: <input type="text"/></p> <p>Batch number: <input type="text"/></p> <p>Batch number: <input type="text"/></p> <p>Batch number: <input type="text"/></p> <p>Batch number: <input type="text"/></p>	<p>Please provide details of any adverse reactions to repeat treatments:</p> <hr/> <hr/> <hr/> <hr/> <hr/>
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Questionnaire for veterinarians

<p>Wound progress</p> <p>Please document wound progress during and following treatment at times of veterinary assessment.</p>	<p>Wound details</p> <p>Appearance: _____</p>			<p>Wound size:</p> <p style="text-align: right;">cm</p>							
	<p>Complications or adverse reactions: _____</p>										
<p>Veterinary assessment number:</p>	<p>Clinical opinion</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">Healing:</td> <td style="width: 25%;">Below average</td> <td style="width: 25%;">Average</td> <td style="width: 25%;">Better than average</td> </tr> <tr> <td>Pain relief / welfare:</td> <td>Below average</td> <td>Average</td> <td>Better than average</td> </tr> </table>			Healing:	Below average	Average	Better than average	Pain relief / welfare:	Below average	Average	Better than average
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Returning this questionnaire

Thank you for your help. The completion of this questionnaire and returning it to us with your photographs will help us understand the efficacy of the Tri-Solfen® product when used for treatment on horses.

Please return all four pages as a scan, or photographs of the completed pages, along with any photographs of the wound and progression through treatment to us at:

info@medicalethics.me

Alternatively, you can fill the questionnaire in using Adobe Acrobat or similar software where comments can be added and return it to us by clicking on the link below. Please remember to save your document first before attaching the file.

Contact us

Australia:
Medical Ethics Pty Ltd
Level 27,
101 Collins Street,
Melbourne,
Victoria 3000

+61 3 8680 2489

United Kingdom:
Medical Ethics UK Ltd
2 Sovereign Quay,
Havannah Street,
Cardiff,
CF10 5SF

+44 (0)207 786 3591

www.medicalethics.me
info@medicalethics.me



Medical Ethics