Pt. No.:

Visit 2.5 – 12 ± 0.5 Hours

Date of Visit: _____/_____/_____ Time completed: _____am / pm

PHYSICAL EXAMINATION:

Body System	Overall interpretation, findings, abnormalities etc.	*Clinically Significant?
Skin (Record Injection Site Assessment)		
Lungs		
Cardiovascular		
Abdomen		
Upper Extremities		
Lower Extremities		
Other:		
Other:		
Other:		

*If any abnormal findings are clinically significant or are changes from baseline, record as Adverse Events

<u>SIGNATURE SECTION</u> – Physical Examination Completed by:

_____ _____ ____/____/___

Printed Name and qualification(s) Signature Date

Visit 2.5 – 12 ± 0.5 Hours

VITAL SIGNS

Time completed: _____am / pm

Blood pressure: _____ / _____mmHg Location: ☐ Arm ☐ Leg ☐ Right ☐ Left

Heart rate: _____bpm Respiratory rate: _____breaths / min

Temperature: _____ ☐°F or ☐°C

Temperature Method: ☐ Oral ☐ Rectal ☐ Axillary ☐ Tympanic (Ear)
☐ Cutaneous Infrared ☐ Other: _____

ECG

Was the ECG taken? ☐ Yes ☐ No: Reason: _____

Time of ECG: _____

Subject Position:

☐ Supine ☐ Semi-Recumbent

☐ Sitting ☐ Other: _____

(Tracing to be reviewed/assessed as clinically significant or non-clinically significant and initialized and dated by investigator; file original and record any findings judged clinically relevant as AEs). Transcribe all findings from the ECG in EDC. QTcF and QTcB will be auto calculated in EDC

INTRACRANIAL HEMORRHAGE (ICH) PATIENTS ONLY

Was 12-hour imaging performed: ☐ Yes ☐ No* Time completed: _____am / pm

**If* No*, reason:* _____

Diagnostic Scan Type: ☐ CT ☐ MRI

Scan with contrast: ☐ Yes ☐ No

Reminder: *1 (one) follow-up CT/MRI scan of the head is required between 12 and 24 hours after completion of the PB2452 infusion. The standard of care diagnostic CT/MRI scans taken at any other timepoint throughout the study will be collected as part of the eCRF.*

Pt. No.:

Visit 2.5 – 12 ± 0.5 Hours

VISIT REMINDERS!

Please complete the following additional source documents

- Central Laboratory Samples (see Laboratory Draw Worksheet) ☐ No ☐ Yes
- Bleeding Location and Hemostasis Assessment ☐ No ☐ Yes
- Surgery/Invasive Procedure Assessment ☐ No ☐ Yes
- Adverse Events / Serious Adverse Events ☐ No ☐ Yes
- Concomitant Therapies ☐ No ☐ Yes
- Blood Products and / or additional supportive treatments ☐ No ☐ Yes

Do not transcribe data points already captured in patient's medical records. Line through and initial duplicate sections above and indicate where source is located.

Additional Information:_____

_____

_____

_____

_____

_____

<u>SIGNATURE SECTION</u> – Visit 2.5 source documents completed by:

_____ _____
____/____/____
Printed Name and qualification(s) Signature Date

<u>PI SIGNATURE SECTION</u> – Principal Investigator signature is required below to signify review:

_____ _____
____/____/____
Printed Name Signature Date