

Therapeutics and Pharmacology Case Report Form

Date that this CRF was filled out: _____

Name of Laboratory/PI: _____

Name of person filling out CRF: _____

Project name/Identifier: _____

Animal ID or Study ID (as applicable): _____

Type of model system:

- Mammalian systems (e.g., rodents, other mammals): _____
- Non-mammalian systems (e.g., *Drosophila*, zebrafish): _____

Type of study:

- Anesthetized: _____
- Non-anesthetized: _____

Endpoint of study:

- Pre-defined time point: _____
- Seizure-induced sudden death: _____
- Other _____

<u>CDE</u>	<u>Data Collected</u>
Type of therapeutic administered (anti-seizure medication)	<input type="checkbox"/> Small molecule <input type="checkbox"/> Biologic <input type="checkbox"/> Anti-sense oligonucleotides <input type="checkbox"/> Dietary therapies / metabolic therapy <input type="checkbox"/> Neurostimulation <input type="checkbox"/> Non-traditional medication <input type="checkbox"/> Other _____
Name of therapy administered; insert details on: <ul style="list-style-type: none">• Name (brand/chemical)• Lot number• Batch number• Supplier Catalog information	_____ _____ _____ _____
Dose	
Frequency of administration	
Method of administration	<input type="checkbox"/> Intraperitoneal (IP) <input type="checkbox"/> Oral gavage <input type="checkbox"/> In food or water <input type="checkbox"/> Intramuscular (IM) <input type="checkbox"/> Intravenous (IV)

	<input type="checkbox"/> Subcutaneous (SC) <input type="checkbox"/> Intrathecal <input type="checkbox"/> Bath immersion <input type="checkbox"/> Other _____
Timeline: when in relation to seizure onset or induction is drug administered	
Name of vehicle or control, if applicable	
Mechanism of action	
How was mechanism of action confirmed, i.e. antagonist administration	
Type of dietary therapy	<input type="checkbox"/> Classic Ketogenic diet <input type="checkbox"/> Low glycemic index therapy <input type="checkbox"/> Modified Atkins <input type="checkbox"/> Other _____
Parameters of dietary therapy	
Types of Neurostimulation A. Site of stimulation B. General parameters i. Duration of stimulation ii. Strength iii. Time	_____ _____ _____ _____
Overall health A. Weight B. Appearance (add in standardized terms)	_____ <input type="checkbox"/> Appeared overall healthy <input type="checkbox"/> Weak/sluggish <input type="checkbox"/> Moribund
Onset of therapeutic effect (time after drug administration)	
Offset of therapeutic effect	
Behavioral seizures	<input type="checkbox"/> Reduction; <input type="checkbox"/> Cessation; <input type="checkbox"/> No effect; <input type="checkbox"/> Other _____
Electrographic seizures	<input type="checkbox"/> Reduction; <input type="checkbox"/> Cessation; <input type="checkbox"/> No effect; <input type="checkbox"/> Other _____
What seizure features were affected?	<input type="checkbox"/> Frequency; <input type="checkbox"/> Duration; <input type="checkbox"/> Other _____
Prevention of respiratory arrest	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown

Prevention of respiratory abnormalities	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Prevention of cardiac abnormalities	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Extension of survival?	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Comments:	
Additional/Adverse Effects	
Known toxicology?	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Motor Effects	
Anesthesia (total loss of feeling or sensation, unresponsive to tail pinch and tapping of the eye)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Ataxia (lack of voluntary coordination of muscle movements, can include wobbly gait)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Loss of righting reflex (unable to turn over when placed in a dorsal recumbent position)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Unable to grasp rotarod (inability to hold on to rotarod in order to begin test)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Minimal motor impairment	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Loss of muscle tone (soft, with low muscle tone)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Sedation (very calm or appear to be sleeping, but will respond to external stimuli)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Altered startle response	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Seizure Effects	
Continuous seizure activity	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Clonic seizures (muscle convulsions of the forelimbs and/or hindlimbs)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Neurological Manifestations	
Intense, repeated jumping straight up	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Myoclonic jerks (non-rhythmic muscle twitch, jerk, shake or spasm)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Wild running (frantic running)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Writhing (a stretch, tension to one side, extension of hind legs, contraction of the abdomen, or twisting of the trunk)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown

Hyperactivity (increased velocity of movement, faster motion than typical)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Severe tremors (strong rhythmic muscle contraction, shaking movements in the limbs or body leading to complete or near incapacitation)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Exophthalmos (eye bulging)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Tremors (rhythmic muscle contraction, shaking movements in the limbs or body)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Muscle spasms (continuous or intermittent muscle contraction or rigidity)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Wet dog shakes (a brief, ~1 second shaking of entire body. not restricted to single body part)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Stretching and rolling (extension/elongation of the body; rolling onto one side with or without completely exposing the ventral body surface)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Retropulsion (backward locomotion or backward circling)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Arching (arching of the back)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Hypoactivity (decreased velocity, slower-than-typical motion)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Physiological Manifestations	
Diarrhea (loose, watery stool)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Salivation (noticeable saliva outside the mouth)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Piloerection (hairs become erect and bristle due to hair follicle contraction i.e., goose bumps)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Hyperesthesia (increase in sensitivity for all senses, i.e., jumping at noises, running or jumping when touched)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Vocalizations (noises audible to humans)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Excessive grooming (intense, excessive or disproportionate body	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown

cleaning; may be restricted to specific body parts, with or without visible signs of tissue damage)	
Urinary staining (pigmented urine)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Bloody urine (bright red urine)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Cold tail (tail feels cold when touched)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Cold to the touch (animal's body feels colder than typical - more severe than cold tail, above)	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Changes in heart rate	<input type="checkbox"/> Yes; <input type="checkbox"/> No; <input type="checkbox"/> Unknown
Other toxic effect	
Comments:	

Abbreviations: CRF: Case Report Form; PI: Principal investigator.

Instructions: Please check boxes where applicable. If none of the predetermined options is appropriate, use the default space to specify your answer. This form is to be filled in for one individual animal, unless otherwise specified.

Please refer to more extensive CRF where suitable, as developed by the ILAE/AES Joint Translational Task Force:

Report on preclinical Core CDEs

<https://onlinelibrary.wiley.com/doi/10.1002/epi4.12234>

Report on preclinical neurobehavioral CDEs

<https://onlinelibrary.wiley.com/doi/10.1002/epi4.12236>

Report on preclinical physiology CDEs

<https://onlinelibrary.wiley.com/doi/10.1002/epi4.12261>

Report on preclinical pharmacology model CDEs

<https://onlinelibrary.wiley.com/doi/10.1002/epi4.12254>

Report on preclinical EEG CDEs

<https://onlinelibrary.wiley.com/doi/10.1002/epi4.12260>