HALT-C Trial

Sustained Virologic Responder Follow-up Ancillary Study: Laboratory Results

Form # 730 Version A: 05/01/2008

SECTION A: GENERAL INFORMATION

A1. Affix ID Label Here → ___ ___ - ___ ___ ___ - ___

A2. Patient initials: __ __ __

A3. Visit number: **_SVR___**

A4. Date form completed: MM / DD / YYYY __ __ / __ __ / __ __ __ __

A5. Initials of person completing form: __ __ __

COMPLETE **ONE** FORM USING THE RESULTS FROM THE MOST RECENT LAB TESTS, PREFERABLY WITHIN THE LAST 6 MONTHS.

FOR ANY SET OF LAB TESTS WHERE NO RESULTS ARE AVAILABLE, WRITE IN "01/01/0101" AS THE DATE OF BLOOD DRAW, AND SKIP TO THE NEXT SECTION.

SECTION B. LABORATORY INFORMATION

B1. Were the lab tests performed at HALT-C Clinical Center or at another location?

HALT-C Clinical Center 1

Performed at a non-HALT-C location..... 2

Other 99

SECTION C. COMPLETE BLOOD COUNT

C1. Date of blood draw: (MM / DD / YYYY) __ __ / __ __ / __ __ __ __

C2. WBC ___ ___ . ___ $x10^3/mm^3$

C3. Hematocrit ___ ___ . ___ %

C4. Hemoglobin ___ ___ . ___ (g/dL)

C5. Platelets ___ ___ ___ $x10^3/mm^3$

Patient ID: ___ ___ - ___ ___ ___ - ___

SECTION D: SERUM CHEMISTRIES

D1. Date of blood draw: (MM / DD / YYYY) __ __ / __ __ / __ __ __ __

D2. Creatinine ___ ___ . ___ (mg/dL)

SECTION E. LIVER CHEMISTRIES

E1. Date of blood draw: (MM / DD / YYYY) __ __ / __ __ / __ __ __ __

E2. AST (SGOT) ___ ___ ___ ___ (U/L)

a. Upper limit of normal (from lab report): ___ ___ ___ (U/L)

E3. ALT (SGPT) ___ ___ ___ ___ (U/L)

a. Upper limit of normal (from lab report): ___ ___ ___ (U/L)

E4. Alkaline phosphatase ___ ___ ___ ___ (U/L)

a. Upper limit of normal (from lab report): ___ ___ ___ (U/L)

E5. Total bilirubin ___ ___ . ___ (mg/dL)

E6. Albumin ___ ___ . ___ (g/dL)

E7. Globulin ___ ___ . ___ (g/dL) **or** Total Protein ___ ___ . ___ (g/dL)

SECTION F. PROTHROMBIN TIME

F1. Date of blood draw: (MM / DD / YYYY) __ __ / __ __ / __ __ __ __

F2. Prothrombin Time ___ . ___ (INR)

Patient ID: ___ ___ - ___ ___ ___ - ___

SECTION G. AFP

G1. Date of blood draw: (MM / DD / YYYY) __ __ / __ __ / __ __ __ __

G2. AFP Result: ___ ___ ___ ___ . ___ ___ ng/ml

a. Upper limit of normal ___ ___ ___ ___. ___ ___ ng/ml

SECTION H: HCV RNA ASSAY INFORMATION

H1. Are the results of an HCV RNA assay since the Week 72 study visit available?

Yes 1

No.....2 **(END OF FORM)**

H2. Date of most recent blood draw: (MM / DD / YYYY) __ __ / __ __ / __ __ __ __

H3. Assay performed: ☐ Specify:_____

HCV RNA Assay Code Box

1. Monitor
2. Amplicor
3. TMA
4. bDNA
5. TAQman (Specify)
6. PCR (Specify)
99. Other (Specify)

H4. HCV RNA Assay Result:

Detected / Positive 1

Not Detected / Negative ..... 2 **(H6)**

H5. Number and Units of HCV RNA Assay Result:

a. Number: _____ (Specify) b. Units: _____ (Specify)

H6. Reference Range:

a. Number: **<**_____ (Specify) b. Units: _____ (Specify)