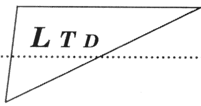
CE



NIDDK

Liver Transplantation Database

INITIAL EVALUATION FORM

CLINICAL & LABORATORY DATA

(Adult and Pediatric)

01/30/1991

COMPLETION LOG

Data Collector ID ________-______________
Center Initials

DATE

Data Collection _____/_____/_____

Data Entry _____/_____/_____

Sysid _____

Verification _____/_____/_____

Cleaned _____/_____/_____

Transfer _____/_____/_____
MM DD YY

SCREENING LOG ID ____ ____ ____
site page line

FORM KEYS

Patient ID ____________________

Date of Evaluation _____/_____/_____

CE

INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

____

This form is to be used for both adult and pediatric initial evaluations; however, the asterisked (*) sections of the clinical form pertain exclusively to pediatric patients and should be completed when appropriate in addition to the main form.

PERSONAL DATA: To Remain at Local LTD Center

1. SOCIAL SECURITY NUMBER ______ - ______ - __________

2. NAME _________________ ____ __________________________ ________________
First M.I. Last Father's Surname

3. If MARRIED

NAME OF SPOUSE __________________________

4. PERMANENT ADDRESS

____

____

_____________________________,___________
City State

____________-______ __________________________________
Zipcode Country

Phone # (   ) _________

***5. Complete for PEDIATRIC PATIENTS**

Provide name(s) of parent(s)/guardian(s) with whom patient resides

First	Last	Relationship
First	Last	Relationship

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INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

____

SSN CODE (last 4 digits) ________

Instructions: To be completed by the attending physician; or by the clinical coordinator based upon review of the patient's medical records and consultation with the attending physician at the end of the initial workup.

I. DEMOGRAPHIC DATA

1. Birthdate ______/______/______
   MM DD YY

   1.1 Is patient a pediatric case (age < 16 years)? Yes__ No__

2. Sex 1. Male__ 2. Female__

3. Race/ethnic background (check one)

   1. Caucasian__ 2. Black__ 3. Am. Indian/Eskimo__ 4. Hispanic__ 5. Oriental Pacific__

   6. Mideast. Arab__ 7. Indian Subcont.__ 8. Other ____
   specify (30 char)

4. Marital status (check one)

   1. Never Married__ 2. Married/Cohabitating__ 3. Separated__ 4. Divorced__

   5. Widowed__

5. Date first seen at transplant center for liver transplant evaluation
   OR Date of re-evaluation if patient was 1st evaluated ≥ 1 year ago ______/______/______
   MM DD YY

II. When was patient/patient's family FIRST TOLD patient had liver disease?

______/______
MM YY

III. SIGNS, SYMPTOMS AND COMPLICATIONS OF LIVER DISEASE

	EVER Yes	EVER No	EVER Unk	IF YES to EVER check whether PAST	CURRENT	DATE 1st Noted
1. Ascites	____	____	____	_____	_____	______/______ MM YY

IF CURRENTLY PRESENT

1.1 TENSE? Yes__ No__

IF EVER YES: 1.2 Currently on THERAPY? Yes__ No__

	EVER Yes	EVER No	EVER Unk	PAST	CURRENT	DATE 1st Noted
2. Bone disease	____	____	____	_____	_____	______/______ MM YY

IF YES

	Yes	No	Unk	PAST	CURRENT
2.1 Bone Pain	____	____	____	_____	_____
2.2 Fractures	____	____	____	_____	_____
2.3 Rickets	____	____	____	_____	_____

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INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

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	EVER			IF YES to EVER check whether		DATE 1st Noted
	Yes	No	Unk	PAST	CURRENT	
2.4 Avascular necrosis	____	____	____	_____	_____	
3. Cholangitis	____	____	____	_____	_____	______/______ MM YY
4. Coagulopathy (with bruising)	____	____	____	_____	_____	______/______
5. Edema (peripheral)	____	____	____	_____	_____	______/______
6. Encephalopathy	____	____	____	_____	_____	______/______

IF CURRENTLY PRESENT

6.1 Specify STAGE as coded ____

1. Lethargy and/or asterixis
2. Confusion and disorientation
3. Stupor or coma, but arousable
4. Deep coma

IF EVER YES — 6.2 Currently on THERAPY? Yes__ No__

	Yes	No	Unk	PAST	CURRENT	DATE 1st Noted
7. Fatigue	____	____	____	_____	_____	______/______
8. GI Bleeding						
8.1 Variceal	____	____	____	_____	_____	______/______

IF EVER YES

8.1.1 No. of variceal bleeds: 1. 1-4 __ 2. ≥ 5 __

8.1.2 Ever endoscopically documented? Yes__ No__

8.1.3 Sclerotherapy given? Yes__ No__

IF YES — 8.1.3.1 No. of sessions: 1. 1-4 __ 2. ≥ 5 __

	Yes	No	Unk	PAST	CURRENT	DATE 1st Noted
8.2 Other type	____	____	____	_____	_____	______/______
9. Jaundice	____	____	____	_____	_____	______/______
10. Pruritis/excoriation	____	____	____	_____	_____	______/______
11. Renal failure (creatinine > 2.0 and/or urine output < 10 ml/kg/24 hrs)	____	____	____	_____	_____	______/______

IF CURRENTLY PRESENT

11.1 Dialysis used? Yes__ No__

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INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

11.2 Type(s) __ 1. Hemodialysis
__ 2. Peritoneal

	EVER			IF YES to EVER check whether		DATE 1st Noted
	Yes	No	Unk	PAST	CURRENT	
12. Spontaneous bacterial peritonitis	____	____	____	_____	_____	______/______ (MM YY)

IF EVER YES

12.1 No. of documented episodes _____

IV. COEXISTING CONDITIONS

	PAST			CURRENT		
	Yes	No	Unk	Yes	No	Unk
1. Arthritis	____	____	____	____	____	____
2. Cardiac disease	____	____	____	____	____	____
IF YES, specify	_______________ (30 char)			_______________ (30 char)		
3. Cataracts	____	____	____	____	____	____
4. Diabetes Mellitus (with insulin)	____	____	____	____	____	____
5. Diabetes Mellitus (no insulin)	____	____	____	____	____	____
6. Gallbladder disease	____	____	____	____	____	____
7. Hypertension (on therapy)	____	____	____	____	____	____
8. Inflammatory bowel disease	____	____	____	____	____	____
9. Malabsorption and/or Steatorrhea	____	____	____	____	____	____
10. Malignancy (excluding liver as primary source)	____	____	____	____	____	____
IF YES, specify	_______________ (30 char)			_______________ (30 char)		
11. Pancreatic disease	____	____	____	____	____	____
IF YES, specify	_______________ (30 char)			_______________ (30 char)		
12. Peptic ulcer disease	____	____	____	____	____	____
13. Psychiatric condition	____	____	____	____	____	____

INITIAL EVALUATION - CLINICAL
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PATIENT ID _________-

____

IF YES, specify

___________________	___________________
(30 char)	(30 char)

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INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

____

	PAST			CURRENT		
	Yes	No	Unk	Yes	No	Unk
14. Pulmonary disease	____	____	____	____	____	____
IF YES, specify	________________ (30 char)			________________ (30 char)		
15. Renal disease	____	____	____	____	____	____
IF YES, specify	________________ (30 char)			________________ (30 char)		
16. Renal lithiasis	____	____	____	____	____	____
17. Seizures	____	____	____	____	____	____
18. Other neurologic disease	____	____	____	____	____	____
IF YES, specify	________________ (30 char)			________________ (30 char)		
19. Thyroid disease	____	____	____	____	____	____
IF YES, specify	________________ (30 char)			________________ (30 char)		
20. Duodenitis/Esophagitis/Gastritis	____	____	____	____	____	____
21. Psoriasis	____	____	____	____	____	____
22. Raynaud's disease	____	____	____	____	____	____
23. Scleroderma/CREST syndrome	____	____	____	____	____	____
24. Other diseases	____	____	____	____	____	____
IF YES, specify	________________ (30 char)			________________ (30 char)		
25. Other diseases	____	____	____	____	____	____
IF YES, specify	________________ (30 char)			________________ (30 char)		
26. Other diseases	____	____	____	____	____	____
IF YES, specify	________________ (30 char)			________________ (30 char)		
27. Other diseases	____	____	____	____	____	____
IF YES, specify	________________			________________		

INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

(30 char) (30 char)

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INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

V. SIGNIFICANT INFECTIONS (clinically documented)

		PAST				CURRENT		
		Yes	No	Unk		Yes	No	Unk
1. Oral herpes (cold sores)		____	____	____		____	____	____
2. Genital herpes		____	____	____		____	____	____
3. Shingles		____	____	____		____	____	____
4. Mononucleosis		____	____	____		____	____	____
5. CMV	____	____	____		____	____	____	
6. Candida (systemic)		____	____	____		____	____	____
7. Other fungal infection (blastomycosis, cryptococcus, coccidioidomycosis, histoplasmosis)	____	____	____		____	____	____	
8. Tuberculosis		____	____	____		____	____	____
9. Clinical hepatitis A		____	____	____		____	____	____
10. Clinical hepatitis B	____	____	____		____	____	____	
11. Clinical hepatitis B + Delta	____	____	____		____	____	____	
12. Clinical hepatitis C	____	____	____		____	____	____	
13. Clinical hepatitis, type unknown		____	____	____		____	____	____
14. Pneumonia		____	____	____		____	____	____
15. Urinary tract infections		____	____	____		____	____	____
16. Septicemia		____	____	____		____	____	____
17. Other	____	____	____		____	____	____	

IF YES, specify ________________ (30 char) ________________ (30 char)

18. Other	____	____	____		____	____	____

IF YES, specify ________________ (30 char) ________________ (30 char)

19. Other	____	____	____		____	____	____

IF YES, specify ________________ (30 char) ________________ (30 char)

20. Other	____	____	____		____	____	____

IF YES, specify ________________ (30 char) ________________ (30 char)

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PATIENT ID _________-

VI. IMMUNIZATIONS

1. Was Hepatitis B vaccine ever administered? Yes__ No__ Unk__

IF YES

- 1.1 No. doses _____
- 1.2 Year of most recent _____

2. Was pneumovax ever administered? Yes__ No__ Unk__

IF YES

- 2.1 Date _____/_____ (MM YY)

*3. IMMUNIZATIONS FOR PEDIATRIC PATIENTS ONLY

3.1 Are immunizations current to date? Yes__ No__ Unk__

IF NO, check the immunizations that are not up to date

__ 3.1.1 Diphtheria	__ 3.1.5 Measles
__ 3.1.2 Pertussis	__ 3.1.6 Mumps
__ 3.1.3 Tetanus	__ 3.1.7 Rubella
__ 3.1.4 Polio	__ 3.1.8 Varicella

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INITIAL EVALUATION - CLINICAL
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PATIENT ID _________-
____

VII. HISTORY OF EXPOSURES (medically documented)

1. POTENTIAL HEPATOTOXIC DRUG EXPOSURE Yes__ No__ Unk__

   IF YES, check if ever used

   __ 1.1 Acetaminophen (greater than recommended dose)
   __ 1.2 Androgens
   __ 1.3 Antabuse (disulfiram)
   __ 1.4 Dilantin
   __ 1.5 Estrogens
   __ 1.6 Isoniazide (INH)
   __ 1.7 Methotrexate
   __ 1.8 Methyldopa
   __ 1.9 Nitrofurantoin
   __1.10 Oral contraceptives
   __1.11 Phenothiazines (Thorazine)
   __1.12 Phenylbutazone
   __1.13 Sulfas
   __1.14 Tegretol
   __1.15 Valproic Acid
   __1.16 Other ____________________________
   __1.17 Other ____________________________
   __1.18 Other ____________________________
   __1.19 Other ____________________________
   specify (30 char)

2. TOXIN EXPOSURE Yes__ No__ Unk__

   IF YES, check all that apply

   __ 2.1 Pesticides
   __ 2.2 Industrial solvents
   __ 2.3 Mushroom toxins
   __ 2.4 Other ____________________________
   __ 2.5 Other ____________________________
   __ 2.6 Other ____________________________

__ 2.7 Other ____
specify (30 char)

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INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

3. DRINKING AND SMOKING HISTORY

3.1 Ever drink alcohol? Yes__ No__ Unk__

IF YES

3.1.1 Currently drink? Yes__ No__ Unk__

IF YES

3.1.1.1 Number of drinks during a typical week _____

IF NO

3.1.1.2 When did patient stop drinking? _____/_____ (MM YY)

3.1.1.3 Previous number of drinks during a typical week _____

3.1.2 For how many years did the patient drink? _____

3.1.3 Has patient ever thought or been told that he/she may have a drinking problem?

Yes__ No__ Unk__

3.2 Ever smoke cigarettes? Yes__ No__ Unk__

IF YES

3.2.1 Currently smoke? Yes__ No__ Unk__

IF YES

3.2.1.1 Average number of packs per week _____

IF NO

3.2.1.2 When did patient stop smoking? _____/_____ (MM YY)

3.2.1.3 Previous average number of packs per week ____

3.2.2 For how many years did the patient smoke? _____

4. FAMILY HISTORY OF LIVER DISEASE Yes__ No__ Unk__

IF YES, specify

	Relation to patient	Liver disease
4.1	______________________	______________________
4.2	______________________	______________________
4.3	______________________	______________________
4.4	______________________	______________________
	(30 char)	(30 char)

PATIENT ID _________-

____

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INITIAL EVALUATION - CLINICAL
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PATIENT ID _________-

VIII. HISTORY OF PRIOR ABDOMINAL SURGERY Yes__ No__ Unk__
IF YES

1. BILIARY SURGERY Yes__ No__ Unk__
IF YES, check all that apply

	Date of most recent
__ 1.1 Percutaneous/endoscopic procedure	_____/_____
__ 1.2 Surgical biliary drainage	_____/_____
__ 1.3 Cholecystectomy	_____/_____
__ 1.4 Common bile duct repair/resection	_____/_____
__ 1.5 Kasai (portoenterostomy)	_____/_____
	MM YY

IF KASAI WAS DONE

Were there revisions? Yes__ No__

IF YES — No. of revisions: 1. One__ 2. > One__

2. HEPATIC RESECTION Yes__ No__ Unk__
IF YES

2.1 Specify reason (check one)
__ 1. Biliary disease
__ 2. Infection
__ 3. Trauma
__ 4. Tumor: malignant
__ 5. Tumor: benign
__ 6. Tumor: polycystic

2.2 Date of most recent _____/_____
MM YY

3. OPEN LIVER BIOPSY Yes__ No__ Unk__

IF YES — 3.1 Date of most recent _____/_____
MM YY

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PATIENT ID _________-

4. PORTOSYSTEMIC SHUNTS Yes__ No__ Unk__

IF YES, check type(s)

	Date of most recent
__ 4.1 Portocaval	_____/_____
__ 4.2 Splenorenal centeral	_____/_____
__ 4.3 Splenorenal distal (Warren)	_____/_____
__ 4.4 Mesocaval	_____/_____
__ 4.5 Other ______________________	_____/_____
__ 4.6 Other ______________________	_____/_____
__ 4.7 Other ______________________	_____/_____
__ 4.8 Other ______________________	_____/_____
specify (30 char)	MM YY

5. PERITONEAL VENOUS SHUNT (Denver, LeVeen) Yes__ No__ Unk__

IF YES

5.1 Date of most recent _____/_____
MM YY

5.2 Were there thrombotic complications? Yes__ No__ Unk__

5.3 Was shunt removed? Yes__ No__ Unk__

IF NO: 5.3.1 Is it patent? Yes__ No__ Unk__

IF YES: 5.3.2 Date removed _____/_____
MM YY

6. SPLENECTOMY Yes__ No__ Unk__

IF YES: 6.1 Date _____/_____
MM YY

INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-________________________________

7. OTHER ABDOMINAL SURGERY or nonbiliary percutaneous intervention

Yes__ No__ Unk__

IF YES, check all that apply

	Date of most recent
__ 7.1 Ulcer	_____/_____
__ 7.2 Esophageal transection	_____/_____
__ 7.3 Colectomy	_____/_____
__ 7.4 Small bowel resections	_____/_____
__ 7.5 Pancreas surgery	_____/_____
__ 7.6 Appendectomy	_____/_____
__ 7.7 OB/GYN	_____/_____
__ 7.8 Other	_____/_____
	MM YY

IX. HISTORY OF BLOOD TRANSFUSIONS Yes__ No__ Unk__

IF YES

	Past 3 mos.	4-6 mos.	7-12 mos.	More than 12 mos.
Number of transfusion episodes	_______	_______	_______	_______

X. PHYSICAL EXAMINATION **DATE OF EXAM** _____/_____/_____
MM DD YY

1. Height _________ cm [_____ ins x 2.54]

2. Weight _________ kg [_____ lbs) 2.2]

3. Nutritional status (check one)
   - __ 1. Excellent (well nourished)
   - __ 2. Fair (mild/moderate depletion or partially repleted)
   - __ 3. Poor (severe depletion)
4. Muscle wasting Yes__ No__
5. Hepatomegaly Yes__ No__

INITIAL EVALUATION - CLINICAL
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PATIENT ID _________-

6. Spleen palpable Yes__ No__

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PATIENT ID _________-

____

* PHYSICAL EXAMINATION for PEDIATRIC PATIENTS ONLY

7. Estimated dry weight _____ kg   _____ lbs) 2.2

   7.1 Percentile height for age (NCHS chart) _____

   7.2 Percentile dry weight for age (NCHS chart) _____

   7.3 Last effective date for best weight percentile: _____/_____/_____
   MM DD YY

8. Head circumference (for patients $\leq$ 3 years of age) _____ cm   _____ ins x 2.54

   8.1 Percentile for age (NCHS chart) _____

9. KARNOFSKY SCALE (check one)   DATE OF ASSESSMENT _____/_____/_____
   MM DD YY

__ 1. Normal, no complaints, no evidence of disease. (Does not look or act like he/she has liver disease and, in the case of adults, admittedly feels fine).

__ 2. Able to carry on normal activity, minor signs or symptoms of disease. (Works/attends school/plays normally in spite of slight or intermittent evidence of disease, e.g. fatigue).

__ 3. Normal activity with effort, some signs or symptoms of disease. (Works/attends school/plays normally but chronically does not feel well, e.g. chronic fatigue, chronic pruritus).

__ 4. Cares for self (consistent with age) but unable to carry on normal activity or to do active work/school/ play. (Has had to quit usual work duties (in or outside of the home)/can no longer attend school/play is more passive than active at this point).

__ 5. Requires occasional assistance (beyond general age appropriate level) but is able to care for most of own needs. (Experiences periods of time when activities of daily living are not possible for him/her to accomplish (appropriate for age). This is the younger child who usually can walk or sit by self but periodically cannot do this independently).

__ 6. Requires considerable assistance and frequent medical care. (Can, at best, only assist with activities of daily living appropriate for age. This is the infant who now needs considerable help with feedings that formerly had been easy. Also has need of frequent clinic and/or hospital visits for management of signs/symptoms of end-stage disease (ie., recurrent cholangitis, encephalopathy, chronic unrelieved pruritus, ascites that is difficult to manage)).

__ 7. Disabled, requires special care and assistance. (Requires total care of most of his/her needs including specialized needs that might include: hemodialysis, tube feeding, home hyperalimentation, etc.).

____

INITIAL EVALUATION - CLINICAL
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KARNOFSKY SCALE (continued)

__ 8. Severely disabled, hospitalization is indicated although death not imminent. (Is not well enough to be managed safely or completely at home any longer).

__ 9. Hospitalization necessary, very sick, active support treatment necessary. (Constant medical and/or surgical intervention to keep patient alive such as: FFP infusions/exchange transfusions to control coagulopathy, frequent infections requiring one or more antibiotics, treatment of variceal bleeds, may or may not need ventilator assistance but probably requires O_2).

__10. Moribund, fatal processes progressing rapidly. (May include the following: multiple infections, hepatic coma, active bleeding, and labile BP requiring vasopressors).

10. **NUMBER OF DAYS HOSPITALIZED** during the past year for liver disease related problems (exclude childbirth, etc.) _____

XI. CURRENT MEDICATION USE Yes__ No__

IF YES, code as specified in Appendix I

	CODE	NAME (30 characters)	Check here if Other med.
1.	____ ____ ____	________________	____
2.	____ ____ ____	________________	____
3.	____ ____ ____	________________	____
4.	____ ____ ____	________________	____
5.	____ ____ ____	________________	____
6.	____ ____ ____	________________	____
7.	____ ____ ____	________________	____
8.	____ ____ ____	________________	____
9.	____ ____ ____	________________	____
10.	____ ____ ____	________________	____
11.	____ ____ ____	________________	____
12.	____ ____ ____	________________	____
13.	____ ____ ____	________________	____
14.	____ ____ ____	________________	____
15.	____ ____ ____	________________	____
16.	____ ____ ____	________________	____
17.	____ ____ ____	________________	____

PATIENT ID _________-

18. ____ ____ ____ ____ ____

INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

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XII. DIAGNOSIS OF LIVER DISEASE

Use code(s) provided in Liver Disease Diagnoses list on opposite page. List in order - primary, secondary, etc., and specify when appropriate.

1. Referral diagnosis (prior to present evaluation)

	Code	Specification (for #5, 9, 12, 17, 19, 20, 27, 28, 32, 35)
1.1	_____	______________________________
1.2	_____	______________________________
1.3	_____	______________________________
		specify (30 char)

2. Current diagnosis (diagnosis at completion of present evaluation)

	Code	Specification (for #5, 9, 12, 17, 19, 20, 27, 28, 32, 35)
1.1	_____	______________________________
1.2	_____	______________________________
1.3	_____	______________________________
		specify (30 char)

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INITIAL EVALUATION - CLINICAL
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PATIENT ID _________-

This page to be completed by Coordinator upon completion of the evaluation of the patient.

XIII. 1. DATE OF MEDICAL ELIGIBILITY as candidate for liver transplantation determined ______/______/______ (MM DD YY)

2. STATUS (check one)

__ 1. Medically acceptable, look for donor

1.1 Date first activated on list ______/______/______ (MM DD YY)

1.2 Contributing reasons for transplantation (must be determined by a physician). Check all that apply:

__ 1.2.1 Bone disease
__ 1.2.2 Encephalopathy
__ 1.2.3 Poor quality of life secondary to fatigue
__ 1.2.4 Pruritis
__ 1.2.5 Recurrent GI bleeding
__ 1.2.6 SBP
__ 1.2.7 Tumor
__ 1.2.8 Uncontrolled ascites
__ 1.2.9 Malnutrition/failure to thrive/failed Kasai procedure
__ 1.2.10 Renal failure
__ 1.2.11 Coagulopathy
__ 1.2.12 Recurrent cholangitis/sepsis/abscess
__ 1.2.13 Other ______________________________ specify (30 char)

1.3 Specify by code the major reason for transplantation from the above list ________

1.4 Code UNOS STATUS as listed on the opposite page ________

__ 2. Suitable, but too well

__ 3. Contraindications

3.1 Check all that apply: 1. Medical__ 2. Financial__ 3. Personal__

3.2 Possibly reversible? Yes__ No__

IF NO reason ______________________________ specify (30 char)

INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

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INITIAL EVALUATION - CLINICAL
NIDDK Liver Transplantation Database

PATIENT ID _________-

XIV. LABORATORY DATA

INSTRUCTIONS: To be completed by the clinical coordinator at the time of the Initial Evaluation of the patient. Results recorded should be the first set of results obtained at the Center; if not done at Center, values sent by the referring physician may be used. Tests preceded by "**" are one-time tests; results may be obtained from 1) previous medical records; 2) the referring physician; or 3) tests done at the clinical center.

1. HEMATOLOGY			Not Done (-2)
	1.1 Hemoglobin (HGB)	___ ___.___g/dl	____
	1.2 Hematocrit (HCT)	___ ___.___%	____
	1.3 Platelet count x 10^3	___,___ ___ ___cells/mm^3	____
	1.4 White blood cells (WBC) x 10^3	___ ___.___cells/mm^3	____
	1.5 Prothrombin time (PT)	__ __.__/__ __.__secs. (Patient / Control)	____
	1.6 Partial thromboplastin time (PTT)	__ __ __.__/__ __ __.__secs. (Patient / Control)	____

Did patient receive exchange transfusion within 48 hours of date of sample? Yes__ No__

**	1.7 Serum iron	__ __ __ug/dl	____
	OR		
**	1.8 Serum ferritin	__ __ __ __ __ __ng/ml	____
**	1.9 Red cell typing		
	1.9.1 Blood type (check one)	1. A __ 2. B __ 3. AB __ 4. O __	
	1.9.2 Rh factor (check one)	+ __ -- __	

2. CLINICAL CHEMISTRY		
2.1 Alkaline phosphatase	__ __ __ __U/L	____
2.2 Total bilirubin	___ ___.__mg/dl	____
2.3 Direct bilirubin	___ ___.__mg/dl	____
2.4 SGOT (AST)	__ __ __ __ __U/L	____
2.5 SGPT (ALT)	__ __ __ __ __U/L	____
2.6 Gamma GTP	__ __ __ __U/L	____
2.7 Albumin	___.___g/dl	____
2.8 Alpha feto-protein	__ __ __ __ __ng/ml	____

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	2.9 Bicarbonate	__ __ __mEq/L	____
			Not Done (-2)
	2.10 Blood urea nitrogen	__ __ __.___mg/dl	____
	2.11 Calcium	__ __.___mg/dl	____
**	2.12 Ceruloplasmin	__ __.___mg/dl	____
	2.13 Chloride	__ __ __mEq/L	____
	2.14 Cholesterol	__ __ __ __mg/dl	____
	2.15 Creatinine	__ __.__mg/dl	____
	2.16 Glucose	__ __ __mg/dl	____
	2.17 Potassium	__.__mEq/L	____
	2.18 Sodium	__ __ __mEq/L	____
	2.19 Total protein	__ __.__g/dl	____

3. URINE STUDIES

3.1 Creatinine clearance __ __ __ml/min ____

Number of hours ______

OR 3.2 GFR (glomerular filtration rate) __ __ __ml/min ____

** 4. IMMUNOLOGY

4.1 Antinuclear antibody (ANA)	Pos ___	Neg ___	____
4.2 Anti-smooth muscle antibody (ASMA)	Pos ___	Neg ___	____
4.3 Anti-mitochondrial antibody (AMA)	Pos ___	Neg ___	____
4.4 Alpha-1-antitrypsin phenotype	___ ___		____

5. GASES - In room air (if possible) 1. Arterial ___ 2. Venous ___ ____

5.1 FiO_2	__.__ __	____
5.2 Hemoglobin O_2 saturation	__ __ __ %	____
5.3 pO_2	__ __ __ mm Hg	____
5.4 pCO_2	__ __ mm Hg	____
5.5 pH	__.__ __	____
5.6 Base excess/deficit	__ __ __ mEq/L	____

5.7 Active bicarbonate __ __ mEq/L ____

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6. INFECTION SCREEN

Viral serologies	RESULTS Pos	RESULTS Neg	Date of Blood Sample	Not Done (-2)
6.1 Anti-CMV IgG	____	____	_____/_____/_____ MM DD YY	____
IF POS: Titer _____________				
6.2 Anti-CMV IgM	____	____	_____/_____/_____	____
6.3 Anti-EBV (VCA) IgG	____	____	_____/_____/_____	____
6.4 Anti-EBV (VCA) IgM	____	____	_____/_____/_____	____
6.5 Anti-HSV	____	____	_____/_____/_____	____
6.6 Anti-HAV	____	____	_____/_____/_____	____
6.7 Anti-HAV IgM	____	____	_____/_____/_____	____
6.8 HBsAg	____	____	_____/_____/_____	____
6.9 Anti-HBc	____	____	_____/_____/_____	____

IF HBsAg POSITIVE

6.10 Anti-HBc IgM	____	____	_____/_____/_____	____
6.11 HBeAg	____	____	_____/_____/_____	____
6.12 Anti-HBe	____	____	_____/_____/_____	____
6.13 Anti-HDV	____	____	_____/_____/_____	____

6.14 Anti-HBs	____	____	_____/_____/_____	____
6.15 Anti-HCV	____	____	_____/_____/_____	____
** 6.16 Anti-HIV	____	____	_____/_____/_____	____

IF HIV POSITIVE

** 6.17 Western Blot	____	____	_____/_____/_____	____

** 6.18 Anti-HTLV1	____	____	_____/_____/_____	____

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XV. COMMENTS: Yes__ No__

IF YES

(60 char/line)