GENERAL INSTRUCTIONS

This form captures procedures performed from the time of the patient's initial hospitalization for this episode of PALF through the first outcome (hospital discharge, liver transplantation, death) or bone marrow transplantation.

If no procedures were performed then the form does not have to be completed.

This form is in log format and each line should be completed as needed to record new information.

SPECIFIC INSTRUCTIONS

Patient ID:	Record the Patient ID
Procedure:	Select the procedure from the list. If a procedure is performed that is not on the list and the investigator feels that the procedure should be captured in the research database, please contact the DCC. CT: Computed Tomography, CAT scan MRI: Magnetic Resonance Imaging MR-spectroscopy: Magnetic Resonance Spectroscopy (MRS), Nuclear Magnetic Resonance (NMR) Paracentesis: remove peritoneal fluid from the peritoneal cavity in the abdomen.
Test Date:	Record the start date for the procedure in month/day/year format (2 digits). If any part of the date is unknown, enter -3 for the unknown part of the date and enter the other parts of the date that are known. If the entire date is unknown, check "Unknown".
Test Time:	Record the start time for the procedure in 24 hour, military time (midnight = 00:00, 8 p.m. = 20:00). If any part of the time is unknown, enter -3 for the unknown part of the time and enter the other parts of the time that are known. If the entire time is unknown, check "Unknown".
Findings:	Record the results of the procedure as normal or abnormal. If the report does not clearly state that the results are normal or abnormal, the results should be interpreted by the investigator.
System ID:	Record the system generated ID for the record.