BABY HUG FOLLOW-UP STUDY II
MAJOR EVENT

PART I: IDENTIFYING INFORMATION

1. Patient's ID Number: ___ ___ ___ ___ SUBJECT_ID
2. Current Clinic: ___ ___ SITE_ID
3. Patient's Letter Code: ___ ___ ___ LETTER_CD
4. Reporting Date: VISIT_DT ___ ___ - ___ ___ - ___ ___ ___ ___
   Month Day Year

PART II: EVENT PERIOD

1. Date of Event
   A. Event Start Date: ___ ___ - ___ ___ - ___ ___ ___ ___ START_DT
      Month Day Year
   B. Event End Date: ___ ___ - ___ ___ - ___ ___ ___ ___ E_END_DT
      Month Day Year

PART III: MAJOR EVENT

1. Please indicate all diagnoses:		YES	NO
A.	Acute Chest Syndrome HX_ACS	(1)	(2)
B.	Splenic Sequestration Crisis HXSPLSEQ	(1)	(2)
C.	Initial or prolonged hospitalization LONGHOSP	(1)	(2)
D.	Stroke or TIA HX_STROKE_TIA	(1)	(2)
E.	Emergency Room Visit	(1)	(2)
F.	Life Threatening LIFE_THREAT_EVT	(1)	(2)
G.	Disability or Permanent Damage	(1)	(2)
H.	Death HX_DEATH	(1)	(2)
I.	ICU Admission ICU	(1)	(2)
J.	Pain crisis	(1)	(2)
K.	Other	(1)	(2)

1. Specify: _____

PART IV: ADDITIONAL DIAGNOSIS INFORMATION

If PART III, Item 1A is YES, answer 1. Otherwise, skip to 2.

1. Acute Chest Syndrome

		None	1 Lobe	>1 Lobe	N/A	
A.	New Infiltrate	(1)	(2)	(3)	(4)	ACSNINF
B.	O_2% Saturation on Room Air at Presentation	_____	_____	. _____%		ACSSRAP
C.	Oxygen Administered	_____	_____	. _____L		ACSOXADM
D.	Mechanical Ventilation	Yes (1)		No (2)		ACSMVENT

If PART III, Item 1B is YES, answer 2. Otherwise, skip to 3.

2. Splenic Sequestration

A. Spleen size below LCM **prior** to Major Event SPLNSIZE_PRIOR

<2 cm	2-4 cm	4-6 cm	6-8 cm	>8 cm
(1)	(2)	(3)	(4)	(5)

B. Spleen size below LCM **during** Major Event SPLNSIZE_DURING

<2 cm	2-4 cm	4-6 cm	6-8 cm	>8 cm
(1)	(2)	(3)	(4)	(5)

C. Nadir hemoglobin ___ ___ . ___ gm/dL SPLNHMGL

D. Platelet count at time of nadir hemoglobin ___ ___ ___ ___ k/µL SPLPTCNT

If PART III, Item 1C is YES, answer 3. Otherwise, skip to 4.

3. Prolonged Hospitalization

A. Reason: LONGHOSP_SP

_____

_____

_____

If PART III, Item 1D is YES, answer 4-5. Otherwise, skip to Part V.

ID Number

4. (Stroke or TIA) Findings of		YES	NO	N/A
A. Loss of consciousness	LOS_CONS	(1)	(2)	(3)
B. Change in mental status	CHG_MENT	(1)	(2)	(3)
C. Loss of or difficulty with speech or vocalization	SPEECH	(1)	(2)	(3)
D. Paralysis or weakness	PARALYS	(1)	(2)	(3)
E. Difficulty with swallowing	DIFFSWAL	(1)	(2)	(3)
F. Difficulty with vision	DIFF_SEE	(1)	(2)	(3)
G. Loss of balance or dizziness	BALANCE	(1)	(2)	(3)
H. Seizures	SEIZURE	(1)	(2)	(3)
I. Headache	HEADACHE	(1)	(2)	(3)

5. Results of Imaging Tests		Normal	Abnormal	Not Done
A. MRI of brain	F50MRI	(1)	(2)	(3)
B. CT scan of brain	F50CTBR	(1)	(2)	(3)
C. PET scan of brain	F50PTBR	(1)	(2)	(3)
D. MRA cerebral vasculature	F50MRA	(1)	(2)	(3)
E. Transcranial Doppler	F50TCD	(1)	(2)	(3)
F. Arteriogram	F50ARTGR	(1)	(2)	(3)
G. Chest x-ray		(1)	(2)	(3)

ID Number

PART V: DIAGNOSIS/PROBLEM SEVERITY AND ATTRIBUTION

Complete PART V for each item in PART III checked YES.

PROBLEM	ONSET_DT	NUMDAYS	SEVERITY	ATTR_TRT	DIAGUNXP
1. Diagnosis/ Problem	2. Date of Onset	3. Number of Days	4. [1]Severity	5. [2]Attribution to Study Treatment	6. [3]Diagnosis Unexpected

[1]Severity	[2]Attribution to Study Test	[3]Diagnosis Unexpected
1. Mild	1. Definite (clearly related)	1. Yes
2. Moderate	2. Probably (likely related)	2. No
3. Severe	3. Possible (may be related)	3. N/A
4. Life threatening	4. Unlikely (doubtfully related)	
5. Disabling	5. Unrelated (definitely not related)	
6. FATAL		
7. Unknown		

PART VI: REPORTABLE TREATMENTS

1. Answer each item — YES NO N/A

A. Transfusion — TRANSFUS (1) (2) (3)

1. If yes, complete a. – d. Otherwise, skip to B.

a. Transfusion Type: TR_TYPE (1) Simple (2) Exchange

b. Volume, answer b 1 or 2.

1. Whole Blood — TRVOLWBL _____ _____ _____ cc

OR

2. Packed Red Cells — TRVOLPR2 _____ _____ _____ cc

ID Number

c. Start Date: TSTRT_DT ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Month Day Year

d. Stop Date: TSTOP_DT ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Month Day Year

			YES	NO	N/A
B.	Placement on chronic transfusion therapy	CHRTRAN	(1)	(2)	(3)
C.	Splenectomy	SPLCTMY	(1)	(2)	(3)
D.	Parenteral antibiotics	PAR_ANTI	(1)	(2)	(3)
E.	Dialysis, limited course	DIALYS_L	(1)	(2)	(3)
F.	Antibiotics		(1)	(2)	(3)
G.	Pain medicine		(1)	(2)	(3)

PART VII: HOSPITALIZATION

1. Admission Date: ADM_DT ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Month Day Year

2. Discharge Date: DISCH_DT ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Month Day Year

PART VIII: OUTCOMES

		YES	NO
1.	Resolved	(1)	(2)
2.	Ongoing	(1)	(2)

ID Number

PART IX: COORDINATION

1. Checked for completeness and accuracy:

   A. Certification number: CERT_NO ___ ___ - ___ ___

   B. Signature: _____ CERT_SIG

   C. General Comments:

   GEN_CMNT

   _____

   _____

   _____

Please Fax the hospital narrative along with this form to the BABY HUG FUP II Data Coordinating Center (DCC) at 443-524-2320.

ID Number
