Baby hug Follow-up Study (BHFS)
PATIENT TREATMENT PLAN

Form 002
Revision 2

Tue Sep 22 10:18:18 EDT 2015

Subject: SUBJECT_ID	Letter Code: LETTER_CD	Visit: VISIT_NBR

1. Visit Date: VISIT_DT

PART II: OPEN LABEL HYDROXYUREA DOSING INFORMATION

1. Date HU Started:	START_DT
2. Dose Started:	DOSE_WEIGHT
3. Dose Form (choose one):	DOSE_FORM

PART III: TREATMENT PLAN

1. A. Is there an ANC below which you will hold open label HU treatment?	ANC_LOW
B. If Yes,	TREAT_DOSE1
1. If Other, then specify:	DOSE_SP1

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2. A. Is there a platelet count below which your institution will hold open label HU treatment?	PLATELET_LOW
B. If Yes,	TREAT_DOSE2
1. If Other, then specify:	DOSE_SP2
C. Is there a hold that can be started based on spleen size or change in spleen size?	SPLEEN_CHANGE
3. A. Is there a hemoglobin below which your institution will hold open label HU treatment:	HEMOGLOBIN_LOW
If No, Skip to Part III.4A.	
If Yes, choose all that apply	
1. 6 gm/dl or below	HEMO_6GM_DL
2. 5.5 gm/dl or below	HEMO_5_5GM_DL
3. 5 gm/dl or below	HEMO_5GM_DL
4. Percentage below baseline	PCT_BELOW_BASELINE
a. If percentage below baseline, specify percentage	BELOW_BASLINE_PERC
5. Other	HEMO_LOW_OTHER
a. If Other, specify:	HEMO_AMOUNT_SP

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4. A. Is there a hemoglobin/reticulocyte combination at which your institution will hold open label HU treatment?	**HEMO_RETICULO**
B. If yes,	
1. Hemoglobin of	**HEMO_AMOUNT2**
2. Absolute Reticulocyte of	**RETICULOCYTE_NUM**
If you answered No to 1, 2, 3 and 4, Skip to Part IV.	
5. If your institution holds HU, when will the patient return for the next blood count (choose one)?	**NEXT_COUNT**
1. If Other, then specify:	**NEXT_COUNT_SP**
6. How much HU does your institution prescribe at each blood count check?	**MEDICATION**
A. If Other, then specify:	**MEDICATION_SP**

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PART IV: COORDINATION

1. Checked for completeness and accuracy:
   - A. Certification number: **CERT_NO**
   - B. Signature **CERT_SIG**
   - C. General Comments **GEN_CMNT**