S25r1 Adverse Event Reporting NonCVA

Ad Hoc Event ID _____

Event Date (yyyy/mm/dd): _____

Correction:
- ☐ Yes
- ☐ No

1. Event Name: _____

2. Event Code (choose one):
- ☐ 010: Vaso-Occlusive Pain
- ☐ 020: Acute Chest Syndrome
- ☐ 030: Fever without source
- ☐ 031: Fever with source
- ☐ 041: Sepsis
- ☐ 042: Meningitis
- ☐ 043: Osteomyelitis
- ☐ 044: Other Bacterial Infection
- ☐ 045: Blood Borne Viral Infection
- ☐ 046: Other Viral Infection
- ☐ 060: Acute Anemia
- ☐ 061: Splenic Sequestion
- ☐ 062: Aplastic Crisis
- ☐ 063: Blood Transfusion Reaction
- ☐ 080: Priapism
- ☐ 090: Surgery (specialty type)
- ☐ 110: New Avascular Necrosis, HIP
- ☐ 120: New Avascular Necrosis, Shoulder
- ☐ 121: Renal Complication (specify)
- ☐ 122: Hematuria
- ☐ 123: Proteinuria
- ☐ 124: Renal Insufficiency
- ☐ 125: Creatinine > 2 x normal
- ☐ 130: Elevated Bilirubin
- ☐ 131: Alanine Transaminase/Asartate Transaminase 4 x normal
- ☐ 132: Alk. Phos. 1 x normal
- ☐ 133: Hypoalbuminemia < 2 x normal
- ☐ 134: Ferritin > 4 x normal
- ☐ 135: Delayed hemolytic transfusion reaction (DHTR)
- ☐ 136: Transfusion Reaction Shock, Oliguria, Hemoglobinuria
- ☐ 137: Asthma
- ☐ 138: Headache
- ☐ 160: Other Event (specify type)

See Toxicity and Non-Neurologic Outcomes Criteria Worksheet 27 for Event Grade Criteria (found in REDCap file repository).

3. Event Grade:
- ☐ 0 - WNL
- ☐ 1 - Mild
- ☐ 2 - Moderate
- ☐ 3 - Severe
- ☐ 4 - Unacceptable

4. Has the patient been seen for the same type of event within the week preceding this visit?
- ☐ Yes
- ☐ No

4A. Does the present history, symptoms, and/or physical exam indicate that this is a continuation of the previous event?
- ☐ Yes
- ☐ No
- ☐ NA

5. Was the patient admitted to the hospital because of this event? If Yes, complete Hospitalization Form 34.
☐ Yes
☐ No

5A. Date of hospital admission (yyyy/mm/dd): _____

5B. Still in hospital?
☐ Yes
☐ No

5C. Date of hospital discharge (yyyy/mm/dd): _____

6. Was this event an infection (sepsis, meningitis, osteomyelitis, or other type)? If YES, complete Infection Complication Form 26.
☐ Yes
☐ No

7. Was this event associated with chelation therapy? If YES, complete Chelation Therapy Complication Form 36.
☐ Yes
☐ No

8. Was this event a headache that required hospitalization or an acute physician visit? If YES, complete Headache Form 14 and/or Hospitalization Form 34.
☐ Yes
☐ No

9. Were there other events associated with this event? If YES, complete separate event form for each event.
☐ Yes
☐ No

10. Date this form completed (yyyy/mm/dd): _____

Staff I.D. #: _____