S55r1 Chelating Agents

Ad Hoc Event ID ______________________________

Visit Date (yyyy/mm/dd): ______________________________

Correction:
- ☐ Yes
- ☐ No

Chelating Agents

1. Did the patient receive a chelating agent? If NO, skip to Staff I.D. #.
- ☐ Yes
- ☐ No

2. Which chelating agent? (choose one)
- ☐ Desferal
- ☐ Exjade
- ☐ Deferipone-L1
- ☐ Other

2A. If Desferal, specify route:
- ☐ IV
- ☐ Subcutaneous

2B. If Other, specify: ______________________________

3. Dose: ______________________________

4. Frequency ______________________________

5. When did the patient start chelating agent (yyyy/mm/dd)? ______________________________

5A. Patient ferritin level at start of chelating agent (xxxx.x ng/ml): ______________________________

6. When did the patient stop chelating agent (yyyy/mm/dd)? ______________________________

6A. Reason for stopping: ______________________________

If Reason for Stopping is chelation therapy complication, complete Form S36r0: Chelation Therapy Complication and Form S25r1: Adverse Event Reporting (nonCVA).

6B. Patient ferritin level at stop date: (xxxx.x ng/ml) ______________________________

Staff I.D. #: ______________________________