MULTICENTER STUDY OF HYDROXYUREA (MSH)

MEDICAL CONTACT

Form 25
Instruction Sheet

A medical contact is a visit of any duration to a doctor, clinic, or hospital, or hospital admission, for an acute event or a new (not pre-existing) medical condition. An emergency room contact resulting in hospitalization is considered a single medical contact. A medical contact has an attending physician associated with it who is the primary source of medical information about the contact. The date and time of presentation and discharge are critical items used to uniquely identify each medical contact and measure its duration.

Information about the contact should be requested from the appropriate facility as soon as possible after the contact to avoid missing information. Although spaces are provided for noting the unavailability of individual items (N/A), they should not be marked "N/A" until all reasonable effort has been made to obtain the information.

Provide a brief description of dose, frequency, and duration of medical treatments administered during the medical contact.

For Item 7A: Yes - *definitely present or clear description indicating presence;*
No - *explicitly denied or a clear clinical description inconsistent with the item or complete clinical description and no mention of the symptom.*
Uncertain - *clinical description is ambiguous or equivocal about the symptom's presence.*

For Item 7B: *Provide the number of days or the number of hours since the onset of the chief symptom(s) for which this medical contact was made.*

For Items 10-16: *Record treatments administered during the medical contact, ie, between date/time of presentation and date/time of discharge.*

For Item 11: *Answer YES if the medical center does not usually use parenteral narcotics or ketorolac for the treatment of sickle cell anemia.*

For Item 12: *Provide the requisite information for the agent listed if the medication prescribed or administered contains the agent. Provide either dose and duration or indicate N/A.*

Instruction Sheet - Continued

For Item 20: *If the patient was discharged within 24 hours of presentation, the time of discharge is to be provided if at all possible. Otherwise, the time of discharge is not necessary.*

Every attempt should be made to provide supporting documentation for laboratory and radiologic studies or any other diagnostic procedures, as well as emergency room notes, doctor's or nurse's notes, etc. Do not report complete blood counts and other hematology studies. In the event of the unavailability of these documents but a personal contact with the attending physician or the like, a summary of key findings identifying the date of the communication and the source of the information may be attached. For all supporting documents, patient names and other personal identifying information are to be obliterated. The patient's MSH patient ID and namecode are to be written on each page of supporting documentation.

FORM REV MSH Form 25
Rev 1 09/30/92

MULTICENTER STUDY OF HYDROXYUREA IN SICKLE CELL ANEMIA (MSH)

MEDICAL CONTACT

CLINIC NO.	CURCLIN
I.D. NO.	- ID
VISIT	- VISIT

PART I: IDENTIFYING INFORMATION

1. Patient Name Code: NAMECODE

PART II: PRESENTATION OF MEDICAL CONTACT

2. A. Date of presentation: ___ ___ - ___ ___ ___ - ___ ___ (Day, Month, Year) PRESDATI

   B. Military time of presentation: ___ ___ : ___ ___

3. Was this medical contact scheduled? ---- (1) Yes (2) No SCH_CONT

4. Locations of contact (ANSWER EACH ITEM):

	Yes	No	
A. 1. Medical doctor's office	(1)	(2)	MED_OFF
2. Emergency facility	(1)	(2)	EMER_F
3. Clinic (not MSH)	(1)	(2)	CLINIC
4. MSH Clinic	(1)	(2)	MSHCL
5. Hospital (in patient)	(1)	(2)	IN_PAT
6. Other	(1)	(2)	

a. Specify ____________

B. Name of Facility

HOSPNAME

C. City

____

D. Telephone number:

___ ___ ___ /___ ___ ___-___ ___ ___ ___

PART III: CLINICAL FINDINGS

5. Were any clinical determinations/evaluations made? ---- (1) Yes (2) No (3) Unknown EVALUATE

   If NO or UNKNOWN, skip to Item 10.

6. What systems were primarily involved? (Answer each item.)

	Yes	No	
A. Central Nervous System	(1)	(2)	NEUR_SYS
B. Pulmonary	(1)	(2)	PULM_SYS
C. Cardiovascular	(1)	(2)	CARD_SYS
D. Genito-urinary	(1)	(2)	URIN_SYS
E. Obstetrical/Gynecological	(1)	(2)	OB_SYS

If YES, answer:
1. Is the patient pregnant (Answer "NO" if uncertain or unknown)? ---- (1) (2) PREGNT

	Yes	No	
F. Gastro-intestinal/abdominal	(1)	(2)	GI_SYS
G. Musculo-skeletal	(1)	(2)	MUSKEL
H. Skin and/or hair	(1)	(2)	SKIN_SYS
I. ENT/upper respiratory tract	(1)	(2)	ENT_SYS
J. Other	(1)	(2)	OTHR_SYS

Specify: SPEC_SYS

7. Were any symptoms present? ---- (1) Yes (2) No (3) Unknown SYMPTOMS

   If NO or UNKNOWN, skip to Item 8.

[PSYCH (1=YES)]

7. Continued:

A. What conditions were present:

	Yes	No	Unknown	
1. Pain	(1)	(2)	(3)	PAIN
2. Distress	(1)	(2)	(3)	DISTRES
3. Sweating	(1)	(2)	(3)	SWEAT
4. Headache	(1)	(2)	(3)	HEADACH
5. Nausea	(1)	(2)	(3)	NAUSEA
6. Vomiting	(1)	(2)	(3)	VOMIT
7. Hair loss	(1)	(2)	(3)	HAIRLOS
8. Skin rash	(1)	(2)	(3)	SKINRSH
9. Bleeding	(1)	(2)	(3)	BLEED
10. Infection	(1)	(2)	(3)	INFECT
11. Fever	(1)	(2)	(3)	FEVER
12. Cough	(1)	(2)	(3)	COUGH
13. Dyspnea	(1)	(2)	(3)	RESP
14. Other	(1)	(2)	(3)	OTH-SYM

DIZ_HEAD
PRIAP
SWELL

Specify: SPEC_SYM

If any item is "YES", answer item 7B.

B. Time from onset of presenting symptoms to medical contact: __ __ (1) days (2) hours — N/A (1)

NSET (days)

8. Vital signs (prior to treatment):

A. Pulse: ___ ___ ___ beats per minute — Not Recorded (1) — PULSE

B. Blood Pressure (mm Hg):

1. Systolic: ___ ___ ___ (1) — SBP

2. Diastolic: ___ ___ ___ (1) — DBP

C. Respiratory rate: ___ ___ ___ per minute (1) — RESPRATE

D. Temperature: ___ ___ ___.___ (1)°F (2)°C (1) — TEMP, TEMP2, CEL_FAR

E. Was scleral icterus present? ------- (1) Yes (2) No (3) Unknown — SCL_ICT

9. Were relevant laboratory data (chemistry, microbiology, urinalysis, radiology/imaging or other studies not hematology) collected? --------- (1) Yes (2) No (3) Unknown — LAB_PERF

If NO or UNKNOWN, skip to Item 10.
If YES, attach appropriate reports (indicating which in Item 21), or if results are available (report not attached), cite key results and the dates verbatim.

A. Results available:

1. ______________________

____

____

If more space needed, attach page(s) to form.

PART IV: TREATMENT

10. Was any treatment administered? ------- (1) Yes (2) No (3) Unknown — TREATED

If NO or UNKNOWN, skip to Part V.

11. Is this a facility where sickle cell anemia patients are routinely treated with oral or transcutaneous analgesics only? -------------- (1) Yes (2) No (3) Unknown — SC_FACIL

I.D. No.					-	
Visit						

12. Was this patient treated with or prescribed oral or transcutaneous narcotics? ---------- (1) Yes (2) No (3) Unknown ORAL_NAR

If NO or UNKNOWN, skip to Item 13.

A. Agent (check all that apply):		B. Total Dose (mg)	C. Days	D. Dose N/A
1. Meperidine (e.g., Demerol) ----	(1) DEM_ORL	DEM_DOSO	DEM_DAO	(1) DEM_O_NA
2. Oxycodone (e.g., Percodan) ----	(1) OXY_ORL	OXY_DOSO	OXY_DAO	(1) OXY_O_NA
3. Morphine (e.g., MS Contin)----	(1) MOR_ORL	MOR_DOSO	MOR_DAO	(1) MOR_O_NA
4. Hydromorphone (e.g., Dilaudid)-	(1) DIL_ORL	DIL_DOSO	DIL_DAO	(1) DIL_O_NA
5. Codeine ----------	(1) COD_ORL	COD_DOSO	COD_DAO	(1) COD_O_NA
6. Fentanyl Patch ----------	(1) FEN_PAT	FEN_DOS	FEN_DA	(1) FEN_NA
Other (Specify):				
7. OR1_RMK	(1) OR1	OR1_DOSO	OR1_DAO	(1) OR1_NA
8. OR2_RMK	(1) OR2	OR2_DOSO	OR2_DAO	(1) OR2_NA

13. Was this patient treated with parenteral non-steroidal anti-inflammatory drug (e.g., Ketorolac) ---------- (1) Yes (2) No (3) Unknown NSAID

If NO or UNKNOWN, skip to Item 14.

A. Agent (check all that apply):		B. Total Dose (mg)	C. Days	D. Dose N/A
1. Ketorolac ----------	(1) KETOR	KET_DOS	KET_DA	(1) KET_NA
2. Other (Specify): NS1_RMK	(1)	NS1_DOS	NS1_DA	(1) NS1_NA

14. Was this patient treated with parenteral narcotics? ---------- (1) Yes (2) No (3) Unknown PAR_NAR

If NO or UNKNOWN, skip to Item 15.

A. Agent (check all that apply):		B. Total Dose (mg)	C. Days	D. Dose N/A
1. Meperidine (e.g., Demerol) ----	(1) DEM_PAR	DEM_DOSP	DEM_DAP	(1) DEM_P_NA
2. Morphine ----------	(1) MOR_PAR	MOR_DOSP	MOR_DAP	(1) MOR_P_NA
3. Hydromorphone (e.g., Dilaudid)-	(1) DIL_PAR	DIL_DOSP	DIL_DAP	(1) DIL_P_NA
Other (Specify):				
4. PA1_RMK	(1)	PA1_DOSP	PA1_DAP	(1) PA1_NA
5. PA2_RMK	(1)	PA2_DOSP	PA2_DAP	(1) PA2_NA

I.D. No.					-	
Visit						

15. Was this patient treated with antibiotics (other than topical)? ------ (1) Yes (2) No (3) Unknown — ANTBIOT

16. Was this patient treated with transfusion? -------- (1) Yes (2) No (3) Unknown — TRANSFUS

If NO or UNKNOWN, skip to Item 17.

A. Total amount of whole blood, packed or adjuvant red cells: ----------- __ __.__ U — UNTBL

PART V: OUTCOME OF THIS MEDICAL CONTACT

17. Disposition (check only one): DISPOSTN

Deceased ------------------- (1)

If deceased, also complete Form 45, Death Notification and Form 46, Cause of Death. Skip to Item 20.

Nursing home --------------- (2)
Own home ------------------- (3)
Other home ----------------- (4)
Other ---------------------- (5)

Specify: ____________________

18. Condition/activity: ACTIVITY

Ambulatory ----------------- (1)
Wheelchair ----------------- (2)
Restricted to bed ---------- (3)

19. Discharge medication (dose, frequency, and duration) prescribed. (Use generic names):

A. ____________________

B. ____________________

C. ____________________

20. Date and time of discharge from this medical contact:

A. Date of discharge:

__ __ - __ __ __ - __ __
Day Month Year

B. Military time of discharge: __ __:__ __ (1) not available

→ DISCDATE

I.D. No.					-	
Visit						

PART VI: COORDINATION

DOCUMENTS

21. Are supporting documents attached? -- Yes (1) No (2)

If NO, skip to Item 22.

	Check if Attached	CC Use Only		
A. Office notes	(1) NOTE_DOC	(1)	(2)	(3)
B. Emergency room records	(1) ER_DOC	(1)	(2)	(3)
C. Hospital discharge summary	(1) HD_ "	(1)	(2)	(3)
D. Physician's letter	(1) MD_	(1)	(2)	(3)
E. Nurse's notes	(1) NURS_	(1)	(2)	(3)
F. Radiology report(s)	(1) RAD_ "	(1)	(2)	(3)
G. Microbiology report(s)	(1) MICR_ "	(1)	(2)	(3)
H. Chemistry report(s)	(1) CHEM_ "	(1)	(2)	(3)
I. Urinalysis report (s)	(1) URIN_ "	(1)	(2)	(3)
J. Narrative summary (MSH Clinic Staff)	(1) NAR_ "	(1)	(2)	(3)
K. Other	(1) OTH_DOC	(1)	(2)	(3)

NOTE_CC
ER_CC

1. Specify: OTH_RMK7

22. Staff member completing this form:

A. Signature: ______________________________

B. Certification No: -- CERT_NO __ __ - __ __

Retain a copy of this form for your files. Send the original to the MSH Data Coordinating Center. Use MSH mailing labels:

MSH Data Coordinating Center
Maryland Medical Research Institute
600 Wyndhurst Avenue
Baltimore, Maryland 21210

CC USE ONLY:

23. Discharge Diagnosis ---------------------------- __ __ __ __ . __

I.D. No.					-	
Visit						