HEIRS CLINICAL EXAM CHECKLIST

Participant ID ☐☐-☐☐-☐☐☐☐☐-☐☐ *[affix ID label here]*

Date of Visit ☐☐/☐☐/☐☐ Month Day Year

Acrostic ☐☐☐☐☐☐

Completed by ☐☐☐

Part 1: Comprehensive Exam Visit

1. Was Consent obtained? 1☐ Yes 2☐ No

2. Was Medical History obtained? 1☐ Yes 2☐ No

3. Was Family History obtained? 1☐ Yes 2☐ No

4. Was the Food Frequency Questionnaire obtained? 1☐ Yes 2☐ No

5. Were medications recorded? 1☐ Yes 2☐ No

6. Was physical exam performed? 1☐ Yes 2☐ No

7. Was blood obtained? 1☐ Yes 2☐ No

8. Were there any clinically significant conditions found? 1☐ Yes 2☐ No

1☐ Yes (if yes ➔)

2☐ No

8a. What was significant?

8b. Referred to physician for follow-up? 1☐ Yes 2☐ No

8c. Name of physician:

8d. Referred by:

8e. Date of referral: ☐☐/☐☐/☐☐ Month Day Year

Part 2: Laboratory Findings

9. Were any clinically significant lab results found?

1☐ Yes (if yes ➔)

2☐ No

9a. What was significant?

9b. Were lab results provided to the participant? 1☐ Yes 2☐ No

9c. TS	1☐ Normal	2☐ Abnormal
9d. SF	1☐ Normal	2☐ Abnormal
9e. DNA	1☐ Normal	2☐ Abnormal
9f. CBC	1☐ Normal	2☐ Abnormal
9g. Glucose	1☐ Normal	2☐ Abnormal
9h. Insulin	1☐ Normal	2☐ Abnormal
9i. ALT	1☐ Normal	2☐ Abnormal
9j. AST	1☐ Normal	2☐ Abnormal
9k. GGT	1☐ Normal	2☐ Abnormal

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Part 2: Laboratory Findings

(continued from lab results)

9l. CRP	1☐ Normal	2☐ Abnormal
9m. Hep B surface antigen	1☐ Normal	2☐ Abnormal
9n. Hep C antibody	1☐ Normal	2☐ Abnormal
9o. Reticulocyte	1☐ Normal	2☐ Abnormal
9p. Haptoglobin	1☐ Normal	2☐ Abnormal
9q. LDH	1☐ Normal	2☐ Abnormal
9r. Indirect bilirubin	1☐ Normal	2☐ Abnormal

9s. Referred to physician for follow-up? 1☐ Yes 2☐ No

9t. Name of physician:

9u. Referred by:

9v. Date of referral: ___/___/___ (Month / Day / Year)

10. Was genetic counseling provided?

1☐ Yes (if yes ➔)

10a. Name of genetic counselor:

2☐ No

10b. Was participant invited to participate in the Family Study?

1☐ Yes 2☐ No