Severe Chronic Neutropenia International Registry	**Patient ID Number**: ___/___ ___/___ ___/___ ___ ___ ___ **Patient Initials**: ___ ___ ___

From: ____/______/____
(DD/MON/YY)

To: ____/______/____
(DD/MON/YY)

YEARLY SUMMARY PATIENT INFORMATION

For RRC use only — Form No: _______

Status: __________

Person completing form: ____
(please print)

REFERRING PHYSICIAN

Name: ____

Institution Name: ____

Institution Address: ____

City/Village: ____

State/Province: ____

Zip/Postal Code: ____

Telephone Number: (   )(   ) ____

Fax Number: (   )(   ) ____

PATIENT DETAILS

Complete only if change from last information provided.

Patient: ____

Address: ____

City/Village: ____

State/Province: ____

Zip/Postal Code: ______________________ Country: ______________________

Telephone Number: (   )(   ) ____

For RRC use only

Sent: ______________________ Data Review: ______________________

Received: ______________________ Entered: ______________________

Clinical Review: ______________________ Verified: ______________________

Severe Chronic Neutropenia International Registry	**Patient ID Number**: ___/___ ___/___ ___/___ ___ ___ ___ **Patient Initials**: ___ ___ ___

From: ____/______/____ To____/______/____
(DD/MON/YY) (DD/MON/YY)

PATIENT INFORMATION YEARLY SUMMARY

EXAMINATIONS AND SIGNIFICANT NON-INFECTIOUS CLINICAL EVENTS

No	Yes	
☐	☐	**Bone marrow** evaluation done Date(s): ____________________________ (Please attach all reports)
☐	☐	AML/MDS
☐	☐	**Cytogenetics** evaluation done Date(s): ____________________________ (Please attach all reports)
☐	☐	Cytogenetic abnormality detected
☐	☐	**Bone density** evaluation done Date(s): ____________________________ (Please attach all reports)
☐	☐	Abnormal bone density/osteopenia/osteoporosis
☐	☐	**In vitro** research testing done
☐	☐	Glomerulonephritis
☐	☐	Vasculitis
☐	☐	Arthritis
☐	☐	Splenectomy Date: _______________
☐	☐	Other significant events including all hospitalizations (specify): ____ ____ ____
☐	☐	Height assessed: __________ cm or __________ in Date: __________
☐	☐	Weight assessed: __________ kg or ___________ lbs Date: ______________
☐	☐	CBCs done during this time period (Please attach all reports)
☐	☐	Patient pregnant during this time period or currently pregnant
☐	☐	Patient died during this time period Date: _______________ Cause of death: ____

Severe Chronic Neutropenia International Registry	Patient ID Number: ___/___ ___/___ ___/___ ___ ___ ___ Patient Initials: ___ ___ ___

From: ____/______/____ To____/______/____
(DD/MON/YY) (DD/MON/YY)

PATIENT INFORMATION YEARLY SUMMARY

SIGNIFICANT INFECTIOUS EPISODES

Frequency	None √	1-3 per Year √	4-12 per Year √	> 12 per Year, Continuous √	Unknown √
Mouth ulcers	☐	☐	☐	☐	☐
Skin abscesses	☐	☐	☐	☐	☐

Other significant infections (specify):	IV Antibiotics administered (√ if yes)
____	☐
____	☐
____	☐
____	☐

TREATMENT

No	Yes	
☐	☐	Cytokine (growth factor, e.g., G-CSF) treatment during this time period Type: ☐ G-CSF ☐ GM-CSF ☐ EPO ☐ Other (specify): ______________________ Current cytokine dose: _________ Units*: _________ Freq**: ________ Brand Name: ________________________ _________ Units*: _________ Freq**: ________ Brand Name: ________________________ Indicate typical dose range for this year: ________________________________
☐	☐	Was cytokine discontinued during this time period: If yes, date discontinued: _____________ Reason: ☐ Ineffective ☐ Pt. chose to withdraw ☐ Toxicity ☐ Neutrophil recovery ☐ Non-compliant ☐ Other, specify ____
☐	☐	Other treatments for neutropenia: ☐ Steroids ☐ Gammaglobulin ☐ Other, specify ______________________________
☐	☐	Bone marrow transplant

*Units	**Freq
mcg	qd
mcg/kg	bid
ml	qod
	qtd
	qwk

BONE MARROW CELL BANK

No	Yes	
☐	☐	Next bone marrow exam planned? If yes: ________/________ (mo / yr)

Please plan to send bone marrow sample to cell bank every year.