

<b>Severe Chronic Neutropenia International Registry</b>  United States Office at the University of Washington	SCNIR 600 Stewart Street, Suite #1503 Seattle, WA 98101	Phone: 206-543-9749 800-726-4463 Fax: 206-543-3668
	<b>SCREENING CHECKLIST</b>	

Physician Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Institution Name: \_\_\_\_\_

Institution Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Country: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Pager: \_\_\_\_\_

Email: \_\_\_\_\_

<b>Patient's Initials:</b> _____ <small>First Middle Last</small>	<b>Date of Diagnosis:</b> ____/____/____ <small>Month Day Year</small>
<b>Date of Birth:</b> ____/____/____ <small>Month Day Year</small>	<b>Diagnosis: (check one)</b>
<b>Sex: (check one)</b>	<input type="checkbox"/> Congenital <input type="checkbox"/> Cyclic* <input type="checkbox"/> Idiopathic <input type="checkbox"/> Autoimmune <input type="checkbox"/> Other (specify): _____
<small>*provide documentation of regular cycling in the form of CBCs done 3x/week for 6 weeks prior to the patient's first ever exposure to cytokine (G-CSF/Neupogen®).</small>	
<small>If your patient has a sub-diagnosis of <b>Barth Syndrome</b>, <b>Shwachman-Diamond Syndrome (SDS)</b>, <b>Glycogen Storage Disease (Type 1b)</b>, or <b>Myelokathexis</b> please submit the corresponding lab evaluations that support the sub-diagnosis (eg, Gene Dx, laboratory reports, SDS report from the SickKids Molecular Genetics Laboratory in Toronto, Canada).</small>	

Evaluation Criteria	Yes	No
Is the patient receiving cytokine (G-CSF/Neupogen®)? Date started: ____/____/____ <small>Month Day Year</small>	<input type="checkbox"/>	<input type="checkbox"/>
3 CBCs with ANC < 0.5 X 10 <sup>9</sup> /L <b>within 3 months before initial dose</b> of cytokine (G-CSF/Neupogen®)?	<input type="checkbox"/>	<input type="checkbox"/>
History of recurrent infections <b>before initial dose</b> of cytokine (G-CSF/Neupogen®)?	<input type="checkbox"/>	<input type="checkbox"/>
Bone marrow evaluation done ( <i>submit copies of all evaluations</i> )?	<input type="checkbox"/>	<input type="checkbox"/>
Cytogenetic evaluation done ( <i>submit copies of all evaluations</i> )?	<input type="checkbox"/>	<input type="checkbox"/>
MDS/Leukemia?	<input type="checkbox"/>	<input type="checkbox"/>
Drug or chemotherapy induced neutropenia? Date of drug/chemotherapy exposure: ____/____/____ <small>Month Day Year</small>	<input type="checkbox"/>	<input type="checkbox"/>
Thrombocytopenia (< 50 X 10 <sup>9</sup> /L)?	<input type="checkbox"/>	<input type="checkbox"/>
Anemia (less than 8 gm/dL)?	<input type="checkbox"/>	<input type="checkbox"/>
Aplastic anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Known immunologic or rheumatologic diseases? (e.g. rheumatoid arthritis, systemic lupus)	<input type="checkbox"/>	<input type="checkbox"/>
Other hematological disorder? (e.g. Felty's Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>