

Severe Chronic Neutropenia International Registry United States Office at the University of Washington	SCNIR 1107 NE 45 th St, Suite #345 Seattle, WA 98105	Phone: 206-543-9749 800-726-4463 Fax: 206-543-3668

SCREENING CHECKLIST

Physician Name: _____ Specialty: _____

Institution Name: _____

Institution Address: _____

City: _____ State/Province: _____ Zip Code: _____ Country: _____

Phone: _____ Fax: _____ Pager: _____

Email: _____

Patient's Initials: _____ <small>First Middle Last</small>	Date of Diagnosis: ____/____/____ <small>Month Day Year</small>
Date of Birth: ____/____/____ <small>Month Day Year</small>	Diagnosis: (check one) <input type="checkbox"/> Congenital <input type="checkbox"/> Cyclic* <input type="checkbox"/> Idiopathic <input type="checkbox"/> Autoimmune <input type="checkbox"/> Other (specify): _____
Sex: (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female	

*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®).

If your patient has a sub-diagnosis of **Barth Syndrome**, **Shwachman-Diamond Syndrome (SDS)**, **Glycogen Storage Disease (Type 1b)**, or **Myelokathexis** 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).

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 ⁹ /L within 3 months before initial dose of cytokine (G-CSF/Neupogen®)?	<input type="checkbox"/>	<input type="checkbox"/>
History of recurrent infections before initial dose 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 ⁹ /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"/>