American Society of Hematology

Sickle Cell Disease Clinical Summary

Contact Information and Demographics	
Name:	**Nickname:**
DOB:	Preferred Language:
Address:	
Cell #: Home #:	Best Time to Reach:
E-Mail:	Best Way to Reach: ☐ Text ☐ Phone ☐ Email
Health Insurance/Plan:	Group and ID #:

Health Care Providers (clinical and emergency information)				
Specialty	Name	Clinic or Hospital	Phone # (daytime clinic # and after hours paging #)	Fax or E-mail Address
Hematologist				
Primary Care				
Name and number of Medical Records Department:				
Allergy Information:				

Educational and Employment Information		
Educational Status / Current Grade Level		
Name of School	Contact Person:	Phone:
Special Accommodations (i.e. Individualized Education Program)		
Employment Status	☐Employed ☐Not Employed	
Name of Employer	Contact Person:	Phone:
Special Accommodations:		

Sickle Cell History	
Diagnosis: SS / SC / SBeta0thal / SBeta+thal / other	Notes:
Has HLA Typing Been Performed? ☐ YES ☐ NO	If yes, please specify type.

Baseline Values Baseline Vital Signs: Ht Wt RR HR BP	
Hemoglobin	g/dL
Reticulocyte Count	%
White Blood Cell Count	10*3/mm3
Total bilirubin	mg/dL
Oxygen Saturation	%
Myelosuppression	

Sickle Cell Complications	
ACS: ☐YES ☐NO	Stroke: ☐ YES ☐ NO
Aplastic Crisis: ☐ YES ☐ NO	Abnormal TCD: ☐ YES ☐ NO
Dactylitis: ☐ YES ☐ NO	ICU admissions: ☐ YES ☐ NO
Retinopathy: ☐ YES ☐ NO	Pulmonary hypertension: ☐ YES ☐ NO
Splenic sequestration: ☐ YES ☐ NO	Asthma: ☐ YES ☐ NO
Priapism: ☐ YES ☐ NO	Bacteremia: ☐ YES ☐ NO
AVN: ☐ YES ☐ NO	Nephropathy: ☐ YES ☐ NO

Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		
Please request individual care plan for patient, if available.		
SC Genotype		
# ED visit for pain in past year		
# hospitalizations for pain in past year		
Pain Plan (i.e. suggested test, treatment, preferred opioid dosing, number of pain episodes per year, other considerations).		
Home Pain Plan:		
ED/inpatient pain plan:		
Preferred opioid:		
Dosing:		
PCA: ☐ YES ☐ NO		
Notes:		

Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations
Fever		

Medications	Dose	Frequency
Hydroxyurea ☐ YES ☐NO If no reason:		

Prior Surgeries, Procedures, and Most Recent Hospitalizations • *Please give dates of most recent admissions for pain*	
Splenectomy: ☐YES ☐ NO	Date
Cholecystectomy: ☐ YES ☐ NO	Date
Port: ☐ YES ☐ NO	Date
Most recent pain admission:	Date
Most recent admission for ACS:	Date

Transfusion History (*Please specify chronic transfusion or chronic exchange*)	(Please note, known Fyantibodies, reaction, and need for pre-medication)

Health Maintenance	**Date**	**Notes**
☐ Cardiology/Echo		
☐ Pulmonary visit		
☐ Dilated eye exam		
☐ UA/urine Microalbumin		

Immunization Summary	**Date**	**Notes**
Pneumovax #1:		
Pneumovax #2:		
Last meningococcal vaccine:		
Last influenza vaccine:		

Relationships
If patient is in a relationship, has she/he been counseled re: SCT testing for partner? ☐ YES ☐ NO
Is partner's SCT status known? ☐ YES ☐ NO
Have the following items been offered (hemoglobinopathy test, correct interpretation, referral to genetic counseling)? ☐ YES ☐ NO

FEMALE	
Menstrual History	
Menses: Onset (Date):	
Menstrual pattern (i.e. regular, irregular, absent):	
Menstrual complications ☐ cramps / non-sickle pain ☐ sickle cell pain	
Contraception	
Current hormonal contraception use and type:	
Previous hormonal contraception use and type:	
Contraception complications: ☐ VTE Thrombosis ☐ Pulmonary Embolism ☐ Other:	
Pregnancy	
Previous pregnancy (list all) ☐ yes ____ (date preg #1). _____(date preg #2) _____(date preg #3)	
Pregnancy outcomes (list all) ☐ Live birth ☐ miscarriage ☐ termination	Treatments in pregnancy: ☐None ☐Chronic transfusion ☐transfusion on demand ☐Hydroxyurea ☐Voxelotor ☐Crizanlizumab ☐L-Glutamine ☐Anticoagulation ☐Other:
Mode of delivery ☐ c-section ☐ Vaginal Delivery (NSVD)	Fetal/infant complications: ☐ IUGR ☐Low birth weight ☐prematurity ☐other:
Pregnancy complications (maternal): ☐ Hypertension/ Pre-eclampsia / eclampsia ☐ Preterm delivery ☐ VTE/PE ☐ still birth ☐ pain crisis ☐ other:	

MALE	
Pregnancy	
History of getting someone pregnant? ☐ YES ☐ NO	
Pregnancy outcome:	

Additional information (i.e. psychosocial issues, family, social background, etc.)
Special information that the patient wants health care professionals to know

Patient/Guardian Signature   Print Name   Phone Number   Date

Primary Care Provider Signature   Print Name   Phone Number   Date

Care Coordinator Signature   Print Name   Phone Number   Date

Please attach the immunization record to this form.