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 *(Circle one)*: 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:				

Emergency Care Plan		
Emergency Contact:	Relationship:	Phone:
Preferred Emergency Care Location:		

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	%

Sickle Cell Complications (Explanation if yes)
ACS: YES or NO
Aplastic Crisis: YES or NO
Dactylitis: YES or NO
Retinopathy: YES or NO
Splenic sequestration: YES or NO
AVN: YES or NO
Priapism: YES or NO
Stroke: YES or NO
Abnormal TCD: YES or NO
ICU admissions: YES or NO
Pulmonary hypertension: YES or NO
Asthma: YES or NO
Bacteremia: YES or NO
Nephropathy: YES or NO

Please attach individual care plan (if available) or fill out the form below:
SC Genotype:
 # ED visits 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 or NO Notes:

Medications	Dose	Frequency
Hydroxyurea YES or NO If no, what is the reason:		
Prior Myelosuppression YES or NO		
Type:		

Prior Surgeries, Procedures, and Most Recent Hospitalizations • *Please give dates of most recent admissions for pain*	
Splenectomy: YES or NO	Date
Cholecystectomy: YES or NO	Date
Port: YES or 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/PFTs		
☐ Dilated eye exam		
☐ UA/urine Microalbumin		
☐ MRI/MRA		
Common Emergent Presenting Problems	Suggested Tests	Treatment Considerations
Fever		
Immunization Summary		
PPSV23 #1:		
PPSV23 #2:		
Last meningococcal vaccine:		
Last influenza vaccine:		

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.