

**Promacta® (eltrombopag)
Bone Marrow Reticulin / Bone Marrow Fibrosis**

Section 1. Patient Information

Initials:	PROMACTA CARES ID:	OCEANS Case No: (For GSK use only)
Age:	Date of Birth: ____ / ____ / ____ (mm / dd / yyyy)	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Section 2. Promacta Therapy

Date when Promacta was started: ____ / ____ / ____ (mm / dd / yyyy)	Is the patient still taking Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what was the dose of Promacta at the time of the event? _____ mg If NO, what were the last dose and the date? _____ mg Date: ____ / ____ / ____ (mm / dd / yyyy)
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Section 3. Adverse Event

Please indicate which adverse event is being assessed. Bone marrow reticulin Bone marrow fibrosis
Date of this event: ____ / ____ / ____ **Is the bone marrow biopsy consistent with the diagnosis of ITP?**
(mm / dd / yyyy) Yes No

Is this a serious adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please indicate the seriousness criteria below: <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization – initial or prolonged <input type="checkbox"/> Congenital anomaly/birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Persistent or significant disability/incapacity <input type="checkbox"/> Other, (important medical events) _____	Outcome of the event: <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved Is this event related to treatment with Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Was the Peripheral Blood Smear Abnormal? Yes No **Date of this smear:** ____ / ____ / ____
(mm / dd / yyyy)

If YES, were any of the following cells present in the peripheral blood smear?
Yes No
 Increased peripheral blast cells Please provide the % _____
 Increased nucleated red blood cells Please provide the % _____
 Tear drop erythrocytes

Bone marrow aspirate <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
Bone marrow biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Silver stain: <input type="checkbox"/> Done <input type="checkbox"/> Not done Results: _____ Trichrome stain: <input type="checkbox"/> Done <input type="checkbox"/> Not done Results:
Immunophenotype <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
Cytogenetics <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:

What clinical features were present at the time of the event? (check all that apply)

<input type="checkbox"/> Recent decrease in hemoglobin	<input type="checkbox"/> Newly diagnosed splenomegaly
<input type="checkbox"/> Recent decrease in platelet counts	<input type="checkbox"/> Newly diagnosed hepatomegaly
<input type="checkbox"/> Increased nucleated red blood cells	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Change in white blood cells, (please specify) _____	

Please quantify the degree of bone marrow reticulin/collagen using the Bauermeister scale. (Select only one)

- 0 No reticulin fibers demonstrable
- 1 Occasional fine individual fibers and foci of a fine fiber network
- 2 Fine fiber network throughout most of the section; no coarse fibers
- 3 Diffuse fiber network with scattered thick coarse fibers but no mature collage (negative trichrome stain)
- 4 Diffuse, often coarse fiber network with areas of collagenization (positive trichrome stain)
- Other (please describe) _____

You may attach anonymized copy of the bone marrow report, if available.

Check this box if attached

Section 4. Medical History - Baseline Assessments

Please complete baseline information on any of the assessments below indicating that any of the following procedures were performed prior to the patient being treated with Promacta?

Bone marrow aspirate	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
Bone marrow biopsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Silver stain: <input type="checkbox"/> Done <input type="checkbox"/> Not done Results: _____ Trichrome stain: <input type="checkbox"/> Done <input type="checkbox"/> Not done Results:
Immunophenotype	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
Cytogenetics	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ (mm / dd / yyyy)	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:

At baseline, please quantify the degree of bone marrow reticulin/collagen using the Bauermeister scale. (Select only 1)

- 0 No reticulin fibers demonstrable
- 1 Occasional fine individual fibers and foci of a fine fiber network
- 2 Fine fiber network throughout most of the section; no coarse fibers
- 3 Diffuse fiber network with scattered thick coarse fibers but no mature collage (negative trichrome stain)
- 4 Diffuse, often coarse fiber network with areas of collagenization (positive trichrome stain)
- Other (please describe) _____

You may attach anonymized copy of the bone marrow report, if available.

Check this box if attached

Section 5. Medical Information

Has the patient received radiation therapy prior to being treated with Promacta? Yes No Unknown

If YES, please specify the body site:

Please indicate any concomitant medications? (check all that apply)

- None
- Azathioprine
- Corticosteroids
- Cyclophosphamide
- Danazol
- Interferon alpha
- IVIg
- Rituximab
- Other (please specify): _____

Please list previous and concurrent disease(s)

None

Section 6. Reporter

- PROMACTA CARES specialist
 - Healthcare Provider
 - Institution
 - Other (specify) _____
- Name and Title _____
Name and Title _____
Name and Title _____
Name and Title _____

Date of this report ____ / ____ / ____ Signature _____
(mm / dd / yyyy)

Promacta® (eltrombopag) Hepatobiliary Laboratory Abnormalities

Section 1. Patient Information		
Initials:	PROMACTA CARES ID:	OCEANS Case No: <small>(For GSK use only)</small>
Age:	Date of Birth: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Section 2. Promacta Therapy		
Date when Promacta was started: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Is the patient still taking Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what was the dose of Promacta at the time of the event? _____ mg If NO, what were the last dose and the date? _____ mg Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>
Section 3. Adverse Event		
What is the adverse event(s)? _____ Date of this event: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>		
Is this a serious adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please indicate the seriousness criteria below: <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization – initial or prolonged <input type="checkbox"/> Congenital anomaly/birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Persistent or significant disability/incapacity <input type="checkbox"/> Other, (important medical events) _____	Outcome of the event: <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved Is this event related to treatment with Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Section 4. Current Liver Function Laboratory Tests		
Please provide the following information regarding the <u>current</u> liver function laboratory tests for this event.		
Dates (mm / dd / yyyy)	Laboratory Test(s)	Reference range
____ / ____ / ____	Alanine Aminotransferase (ALT) =	
____ / ____ / ____	Aspartate Aminotransferase (AST) =	
____ / ____ / ____	Total Bilirubin =	
____ / ____ / ____	Direct Bilirubin (<i>only if total bilirubin is elevated</i>) =	
____ / ____ / ____	Alkaline Phosphatase =	
You may attach anonymized copy of these reports, if available.		<input type="checkbox"/> Check this box, if attached
Section 5. Liver Biopsy		
Was a liver biopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, What were the results? _____		
You may attach anonymized copy of these reports, if available.		<input type="checkbox"/> Check this box, if attached

Section 6. Diagnostic Imaging

Were any of the following diagnostic imaging tests of the hepatobiliary system performed?

- | | | |
|--------------------------|--------------------------|---|
| Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver Ultrasound |
| <input type="checkbox"/> | <input type="checkbox"/> | CAT Scan |
| <input type="checkbox"/> | <input type="checkbox"/> | MRI Scan |
| <input type="checkbox"/> | <input type="checkbox"/> | Endoscopic/Magnetic Retrograde Cholangiopancreatography (ERCP) / (MRCP) |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____ |

You may attach anonymized copy of these reports, if available.

Check this box, if attached

Section 7. Medical Information

Does the patient have a history of drug allergies? Yes No

Any concomitant medication(s)? Yes No None

If YES, please list drug(s) below

Please list concurrent disease(s)

None

Section 8. Liver Function Laboratory Tests - Peak and Return to Baseline Values

Please provide the following information regarding the peak and return to baseline liver function laboratory tests, if available.

Dates (mm / dd / yyyy)	Laboratory Test(s)	Reference ranges
____ / ____ / ____ ____ / ____ / ____	peak Alanine Aminotransferase (ALT) = return to baseline Alanine Aminotransferase =	
____ / ____ / ____ ____ / ____ / ____	peak Aspartate Aminotransferase (AST) = return to baseline Aspartate Aminotransferase =	
____ / ____ / ____ ____ / ____ / ____	peak total Bilirubin = return to baseline Bilirubin =	
____ / ____ / ____ ____ / ____ / ____	<i>(only if total bilirubin is elevated)</i> peak Direct Bilirubin = return to baseline Direct Bilirubin =	
____ / ____ / ____ ____ / ____ / ____	peak Alkaline Phosphatase (Alk Phos) = return to baseline Alkaline Phosphatase =	

You may attach anonymized copy of these reports, if available.

Check this box, if attached

Section 9. Reporter

PROMACTA CARES specialist

Healthcare Provider

Institution

Other (specify) _____

Name and Title _____

Name and Title _____

Name and Title _____

Name and Title _____

Date of this report ____ / ____ / ____
(mm / dd / yyyy)

Signature _____

Section 1. Patient Information		
Initials:	PROMACTA CARES ID:	OCEANS Case No: <small>(For GSK use only)</small>
Age:	Date of Birth: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Section 2. Promacta Therapy		
Date when Promacta was started: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Is the patient still taking Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what was the dose of Promacta at the time of the event? _____ mg If NO, what were the last dose and the date? _____ mg Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>
Section 3. Adverse Event		
What is the adverse event(s)? _____ Date of this event: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>		
Is this a serious adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please indicate the seriousness criteria below: <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization – initial or prolonged <input type="checkbox"/> Congenital anomaly/birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Persistent or significant disability/incapacity <input type="checkbox"/> Other, (important medical events) _____	Outcome of the event: <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved Is this event related to treatment with Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Section 4. Diagnosis		
Please select one choice regarding this event: <input type="checkbox"/> New diagnosis <input type="checkbox"/> Relapse of previous malignancy <input type="checkbox"/> Unknown		
Please select one diagnosis from this list : <input type="checkbox"/> AML (FAB subtype): _____ <input type="checkbox"/> MDS (IPSS score): _____ <input type="checkbox"/> Lymphoma (specify): _____		
<input type="checkbox"/> Under investigation <input type="checkbox"/> Myeloproliferative Disease (MPD) Please specify: <input type="checkbox"/> CML <input type="checkbox"/> IMF <input type="checkbox"/> PV <input type="checkbox"/> ET <input type="checkbox"/> Other, (specify): _____		
Is the peripheral blood smear abnormal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Bone marrow aspirate? <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
Bone marrow biopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
Immunophenotype? <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
Cytogenetics? <input type="checkbox"/> Yes <input type="checkbox"/> No	____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Abnormalities: <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please specify:
You may attach anonymized copy of these reports, if available. <input type="checkbox"/> Check this box, if attached		

Please provide any additional information on stage, treatment planned, pathology, and x-ray findings.

None

You may attach anonymized copy of these reports, if available. Check this box, if attached

What clinical features were present at the time of diagnosis? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Granulocytopenia |
| <input type="checkbox"/> Pallor | <input type="checkbox"/> Thrombocytopenia |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lymphadenopathy |
| <input type="checkbox"/> Fever/night sweats | <input type="checkbox"/> Increased bruising/bleeding |
| <input type="checkbox"/> Bone pain | <input type="checkbox"/> Recurrent infection/poor wound healing |
| <input type="checkbox"/> Hepatosplenomegaly | <input type="checkbox"/> Abdominal pain and /or weight loss |
| <input type="checkbox"/> Other (please specify): _____ | |

Section 5. Medical Information

Does the patient have any of the following past or present conditions that may predispose them to malignancies?

None

Yes No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Family History of malignancy |
| <input type="checkbox"/> | <input type="checkbox"/> | Smoking |
| <input type="checkbox"/> | <input type="checkbox"/> | Occupational exposure (e.g. benzene) |
| <input type="checkbox"/> | <input type="checkbox"/> | Monoclonal gammopathy |
| <input type="checkbox"/> | <input type="checkbox"/> | History of chemotherapy or radiation therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (please specify) _____ |

What are the concomitant medications? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Interferon alpha |
| <input type="checkbox"/> Azathioprine | <input type="checkbox"/> IVIg |
| <input type="checkbox"/> Corticosteroids | <input type="checkbox"/> Rituximab |
| <input type="checkbox"/> Cyclophosphamide | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Danazol | |

Section 6. Reporter

- | | |
|--|----------------------|
| <input type="checkbox"/> PROMACTA CARES specialist | Name and Title _____ |
| <input type="checkbox"/> Healthcare Provider | Name and Title _____ |
| <input type="checkbox"/> Institution | Name and Title _____ |
| <input type="checkbox"/> Other (specify) _____ | Name and Title _____ |

sm5g

Date of this report ____ / ____ / ____ Signature _____
(mm / dd / yyyy)

**Promacta® (eltrombopag)
Worsening Thrombocytopenia and Bleeding**

Section 1. Patient Information		
Initials:	PROMACTA CARES ID:	OCEANS Case No: <small>(For GSK use only)</small>
Age:	Date of Birth: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Section 2. Promacta Therapy		
Date when Promacta was started: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Is the patient still taking Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what was the dose of Promacta at the time of the event? _____ mg If NO, what were the last dose and the date? _____ mg Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>
Section 3. Adverse Event		
What is the adverse event(s)? _____ Date of this event: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>		
Is this a serious adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please indicate the seriousness criteria below: <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization – initial or prolonged <input type="checkbox"/> Congenital anomaly/birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Persistent or significant disability/incapacity <input type="checkbox"/> Other, (important medical events) _____	Outcome of the event: <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved Is this event related to treatment with Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What is the platelet count most proximal to this event? _____ unit Normal range _____		
Describe any bleeding symptoms during the event? <input type="checkbox"/> None		
Was a transfusion required to maintain the baseline hemoglobin? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____ Please provide the date(s)		
Please provide up to the last four platelet counts <u>before</u> the first day of treatment with Promacta.		
<input type="checkbox"/> Date _____ Platelet count _____ Normal range _____		
<input type="checkbox"/> Date _____ Platelet count _____ Normal range _____		
<input type="checkbox"/> Date _____ Platelet count _____ Normal range _____		
<input type="checkbox"/> Date _____ Platelet count _____ Normal range _____		
You may attach anonymized copy of these reports, if available.		<input type="checkbox"/> Check this box, if attached

Section 4. Medical Information

Were there any similar bleeding events prior to therapy with Promacta? Yes No

If YES, please describe:

Has the patient experienced bleeding symptoms on discontinuation of other treatments for ITP? Yes No

If YES, please describe:

Please list concurrent disease(s) None

Were there any changes to the concomitant therapy(ies) for ITP prior to this event? Yes No

If YES, please specify:

Please list concurrent medication(s) (e.g. anti-platelet medications, NSAIDs) None

Section 5. Reporter

PROMACTA CARES specialist

Name and Title _____

Healthcare Provider

Name and Title _____

Institution

Name and Title _____

Other (specify) _____

Name and Title _____

smg

Date of this report ____ / ____ / ____
(mm / dd / yyyy)

Signature _____

Promacta® (eltrombopag) Thrombotic and Thromboembolic Events

Section 1. Patient Information																																										
Initials:	PROMACTA CARES ID:	OCEANS Case No: <small>(For GSK use only)</small>																																								
Age:	Date of Birth: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female																																								
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Date when Promacta was started: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	Is the patient still taking Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, what was the dose of Promacta at the time of the event? _____ mg If NO, what were the last dose and the date? _____ mg Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>																																								
Section 3. Adverse Event																																										
Adverse Event(s) _____		Date of this event: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>																																								
What was the <u>most proximal</u> platelet count to the time of this event? Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	What was the platelet count <u>after</u> this event? Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>																																									
Is this a serious adverse event? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please indicate the seriousness criteria below: <input type="checkbox"/> Death <input type="checkbox"/> Hospitalization – initial or prolonged <input type="checkbox"/> Congenital anomaly/birth defect <input type="checkbox"/> Life-threatening <input type="checkbox"/> Persistent or significant disability/incapacity <input type="checkbox"/> Other, (important medical events) _____		Outcome of the event: <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved Is this event related to treatment with Promacta? <input type="checkbox"/> Yes <input type="checkbox"/> No																																								
Section 4. Diagnostic Tests																																										
<table style="width: 100%; border: none;"> <tr> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 70%;">CT Scan</td> <td style="width: 10%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Phlebography</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Doppler/Ultrasound</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>V/P scintigraphy</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Echocardiography</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>ECG</td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Blood-gas analysis</td> <td></td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	CT Scan		<input type="checkbox"/>	<input type="checkbox"/>	Phlebography		<input type="checkbox"/>	<input type="checkbox"/>	Doppler/Ultrasound		<input type="checkbox"/>	<input type="checkbox"/>	V/P scintigraphy		<input type="checkbox"/>	<input type="checkbox"/>	Echocardiography		<input type="checkbox"/>	<input type="checkbox"/>	ECG		<input type="checkbox"/>	<input type="checkbox"/>	Blood-gas analysis		Other tests? Please specify _____ _____ Please provide anonymized copy of these reports, if available. <input type="checkbox"/> Check this box, if attached													
<input type="checkbox"/>	<input type="checkbox"/>	CT Scan																																								
<input type="checkbox"/>	<input type="checkbox"/>	Phlebography																																								
<input type="checkbox"/>	<input type="checkbox"/>	Doppler/Ultrasound																																								
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<table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 15%;">Normal</th> <th style="width: 15%;">Abnormal</th> <th style="width: 15%;">Not Done</th> <th style="width: 55%;"></th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Lupus anticoagulants</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Antiphospholipid antibodies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anti-prothombin antibodies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Beta 2 glycoprotein antibodies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Factor VIII</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Protein C</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Protein S</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Serum homocysteine</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Anti-thrombin III</td></tr> </tbody> </table>	Normal	Abnormal	Not Done		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antiphospholipid antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-prothombin antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Beta 2 glycoprotein antibodies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Factor VIII	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Protein C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Protein S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serum homocysteine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-thrombin III		
Normal	Abnormal	Not Done																																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus anticoagulants																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antiphospholipid antibodies																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-prothombin antibodies																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Beta 2 glycoprotein antibodies																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Factor VIII																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Protein C																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Protein S																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serum homocysteine																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anti-thrombin III																																							

Thrombophilic Laboratory Profile continued

Normal	Abnormal	Not Done			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Factor V Leiden mutation	<input type="checkbox"/> Heterozygous	<input type="checkbox"/> Homozygous <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prothrombin mutation	<input type="checkbox"/> Heterozygous	<input type="checkbox"/> Homozygous <input type="checkbox"/> Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MTHFR-Polymorphism	<input type="checkbox"/> Heterozygous	<input type="checkbox"/> Homozygous <input type="checkbox"/> Unknown

You may attach anonymized copy of these reports, if available. Check this box, if attached

Section 5. Medical Information

Please indicate below if the patient has ever had any of the following conditions.

		<input type="checkbox"/> None
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus
<input type="checkbox"/>	<input type="checkbox"/>	Hyperlipidemia
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular disease
<input type="checkbox"/>	<input type="checkbox"/>	Thromboembolic event
<input type="checkbox"/>	<input type="checkbox"/>	Family history of thromboembolism
<input type="checkbox"/>	<input type="checkbox"/>	Varicose Vein(s)

RISK FACTORS

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Was there trauma prior to the event?
<input type="checkbox"/>	<input type="checkbox"/>	Was the patient immobilized /hospitalized prior to this event (e.g. surgical procedures)? If YES, was prophylactic anticoagulation administered? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>	If female, is the patient taking oral contraceptives?
<input type="checkbox"/>	<input type="checkbox"/>	If female, has the patient taken hormone replacement therapy?
<input type="checkbox"/>	<input type="checkbox"/>	Evidence of any autoimmune disease at any time other than ITP (e.g. IBD, SLE, RhA, etc.)? If YES, please describe:

Please list past or concomitant medication(s) (e.g. IVIG, diuretics, corticosteroids, aminocaproic acid, antifibrinolytic agents, etc.)

None

Section 6. Reporter

<input type="checkbox"/> PROMACTA CARES specialist	Name and Title _____
<input type="checkbox"/> Healthcare Provider	Name and Title _____
<input type="checkbox"/> Institution	Name and Title _____
<input type="checkbox"/> Other (specify) _____	Name and Title _____

Date of this report ____ / ____ / ____ Signature _____
(mm / dd / yyyy)