

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

**Section 1. Patient Information**

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

**Section 2. Promacta Therapy**

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

<b>Is this a serious adverse event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If YES, please indicate the seriousness criteria below:</b> <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) _____	<b>Outcome of the event:</b> <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved  <b>Is this event related to treatment with Promacta?</b> <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

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

**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)

Anemia

Pallor

Fatigue

Fever/night sweats

Bone pain

Hepatosplenomegaly

Other (please specify): \_\_\_\_\_

Granulocytopenia

Thrombocytopenia

Lymphadenopathy

Increased bruising/bleeding

Recurrent infection/poor wound healing

Abdominal pain and /or weight loss

### 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

Family History of malignancy

Smoking

Occupational exposure (e.g. benzene)

Monoclonal gammopathy

History of chemotherapy or radiation therapy

Other (please specify) \_\_\_\_\_

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

None

Azathioprine

Corticosteroids

Cyclophosphamide

Danazol

Interferon alpha

IVIg

Rituximab

Other (please specify): \_\_\_\_\_

### 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
( mm / dd / yyyy)

Signature \_\_\_\_\_

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

**Section 1. Patient Information**

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

**Section 2. Promacta Therapy**

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

**What is the adverse event(s)?** \_\_\_\_\_ **Date of this event:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
( mm / dd / yyyy)

<p><b>Is this a serious adverse event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If YES, please indicate the seriousness criteria below:</b></p> <p><input type="checkbox"/> Death</p> <p><input type="checkbox"/> Hospitalization – initial or prolonged</p> <p><input type="checkbox"/> Congenital anomaly/birth defect</p> <p><input type="checkbox"/> Life-threatening</p> <p><input type="checkbox"/> Persistent or significant disability/incapacity</p> <p><input type="checkbox"/> Other, (important medical events) _____</p>	<p><b>Outcome of the event:</b></p> <p><input type="checkbox"/> Resolved</p> <p><input type="checkbox"/> Resolving/recovering</p> <p><input type="checkbox"/> Resolved with sequelae</p> <p><input type="checkbox"/> Not resolved</p> <p><b>Is this event related to treatment with Promacta?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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**What is the platelet count most proximal to this event?** \_\_\_\_\_ unit \_\_\_\_\_ **Normal range** \_\_\_\_\_

**Describe any bleeding symptoms during the event?**  None

**Was a transfusion required to maintain the baseline hemoglobin?**  Yes  No **If yes, how many?** \_\_\_\_\_

**Please provide the date(s)**

**Please provide up to the last four platelet counts before the first day of treatment with Promacta.**

**Date** \_\_\_\_\_ **Platelet count** \_\_\_\_\_ **Normal range** \_\_\_\_\_

**Date** \_\_\_\_\_ **Platelet count** \_\_\_\_\_ **Normal range** \_\_\_\_\_

**Date** \_\_\_\_\_ **Platelet count** \_\_\_\_\_ **Normal range** \_\_\_\_\_

**Date** \_\_\_\_\_ **Platelet count** \_\_\_\_\_ **Normal range** \_\_\_\_\_

**You may attach anonymized copy of these reports, if available.**  **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																										
<b>Initials:</b>	<b>PROMACTA CARES ID:</b>	<b>OCEANS Case No:</b> <small>(For GSK use only)</small>																								
<b>Age:</b>	<b>Date of Birth:</b> ____ / ____ / ____ <small>( mm / dd / yyyy)</small>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female																								
Section 2. Promacta Therapy																										
<b>Date when Promacta was started:</b> ____ / ____ / ____ <small>( mm / dd / yyyy)</small>	<b>Is the patient still taking Promacta?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If YES, what was the dose of Promacta at the time of the event?</b> _____ mg <b>If NO, what were the last dose and the date?</b> _____ mg <b>Date:</b> ____ / ____ / ____ <small>(mm / dd / yyyy)</small>																								
Section 3. Adverse Event																										
<b>Adverse Event(s)</b> _____		<b>Date of this event:</b> ____ / ____ / ____ <small>( mm / dd / yyyy)</small>																								
<b>What was the <u>most proximal</u> platelet count to the time of this event?</b>  Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>	<b>What was the platelet count <u>after</u> this event?</b>  Date: ____ / ____ / ____ <small>(mm / dd / yyyy)</small>																									
<b>Is this a serious adverse event?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If YES, please indicate the seriousness criteria below:</b> <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) _____		<b>Outcome of the event:</b> <input type="checkbox"/> Resolved <input type="checkbox"/> Resolving/recovering <input type="checkbox"/> Resolved with sequelae <input type="checkbox"/> Not resolved  <b>Is this event related to treatment with Promacta?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No																								
Section 4. Diagnostic Tests																										
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;"><b>Yes</b></td> <td style="width: 5%;"><b>No</b></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>CT Scan</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Phlebography</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Doppler/Ultrasound</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>V/P scintigraphy</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Echocardiography</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>ECG</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Blood-gas analysis</b></td> </tr> </table>	<b>Yes</b>	<b>No</b>		<input type="checkbox"/>	<input type="checkbox"/>	<b>CT Scan</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Phlebography</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Doppler/Ultrasound</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>V/P scintigraphy</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Echocardiography</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>ECG</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Blood-gas analysis</b>	<b>Other tests? Please specify</b> _____ _____  <b>Please provide anonymized copy of these reports, if available.</b> <input type="checkbox"/> Check this box, if attached	
<b>Yes</b>	<b>No</b>																									
<input type="checkbox"/>	<input type="checkbox"/>	<b>CT Scan</b>																								
<input type="checkbox"/>	<input type="checkbox"/>	<b>Phlebography</b>																								
<input type="checkbox"/>	<input type="checkbox"/>	<b>Doppler/Ultrasound</b>																								
<input type="checkbox"/>	<input type="checkbox"/>	<b>V/P scintigraphy</b>																								
<input type="checkbox"/>	<input type="checkbox"/>	<b>Echocardiography</b>																								
<input type="checkbox"/>	<input type="checkbox"/>	<b>ECG</b>																								
<input type="checkbox"/>	<input type="checkbox"/>	<b>Blood-gas analysis</b>																								
Thrombophilic Laboratory Profile																										
Normal	Abnormal	Not Done																								
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lupus anticoagulants</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Antiphospholipid antibodies</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Anti-prothombin antibodies</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Beta 2 glycoprotein antibodies</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Factor VIII</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Protein C</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Protein S</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Serum homocysteine</b>																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Anti-thrombin III</b>																							

**Thrombophilic Laboratory Profile continued**

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

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"/>	<b>Hypertension</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Diabetes Mellitus</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hyperlipidemia</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Cardiovascular disease</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Thromboembolic event</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Family history of thromboembolism</b>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Varicose Vein(s)</b>

**RISK FACTORS**

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