ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
CENTRAL LABORATORY PATIENT INFORMATION FORM

Form Completion Instructions:

Form #00 should be completed and accompany all blood samples sent to the Central Laboratory. The form should NOT be sent to the Clinical Coordinating Center. Be sure to complete each section of the form.

The Central Laboratory will forward a hard copy of the form to the Clinical Coordinating Center when the results from their testing are complete.

Be very careful to complete each item on BOTH pages of the form.

ALPHA 1-ANTITRYPSIN DEFICIENCY REGISTRY
Central Laboratory
Patient Information Form

PLEASE PRINT OR TYPE:

1. Date form completed: F00Q01_fzd (fuzzed) ___/___/___ (month day year)
2. Patient Registry ID: newID (scrambled) _____
3. Patient Name code: namecode (censored) _____
4. Clinical Center: clinic (censored) ..... Code: ___
5. Patient name: never entered into original database ___ (Last) (First) (MI)
6. Sex: F00Q06 (1) Male (2) Female (3) Pregnant Female
7. Date of birth: F00Q07_fzd (fuzzed) ___/___/___ (month day year)
8. Serum kit number: F00Q08 (censored) _____
9. Date blood drawn: F00Q09_fzd (fuzzed) ___/___/___ (month day year)
10. Date of last infusion of alpha 1-antitrypsin: F00Q10_fzd ___/___/___ (month day year)
    (Enter "00/00/00" if not applicable)

CLINICAL HISTORY:

11. Currently taking medications listed below (11a - d) ?: F00Q11 ___(1)Yes ___(2)No
    If YES, complete the following:
    a. Birth Control Pills: F00Q11A ___(1)Yes ___(2)No
    b. Tamoxifen: F00Q11B ___(1)Yes ___(2)No
    c. Corticosteroids: F00Q11C ___(1)Yes ___(2)No
    d. Danazol: F00Q11D ___(1)Yes ___(2)No
12. History of Smoking: F00Q12 ___(1)Yes ___(2)No
    If YES, complete the following:
    a. Ex-cigarette smoker: F00Q12A ___(1)Yes ___(2)No
    b. Current cigarette smoker: F00Q12B ___(1)Yes ___(2)No
    c. Number of Pack Years of Cigarettes: F00Q12C _____
    d. Other smoking: (Specify: → Never entered) F00Q12D (1)Yes ___(2)No

(Please complete important information on Page 2)

Patient Registry ID: ___ ___ ___ ___ ___
Patient Name Code: ___ ___ ___ ___

13. History and/or evidence of lung disease: F00Q13 ___(1)Yes ___(2)No
    If YES, complete the following:
    a. Emphysema: F00Q13A ___(1)Yes ___(2)No
    b. Reversible Airways Disease: F00Q13B ___(1)Yes ___(2)No
    c. Bronchitis: F00Q13C ___(1)Yes ___(2)No
14. History and/or evidence of liver disease: F00Q14 ___(1)Yes ___(2)No
    If YES, complete the following:
    a. Cirrhosis: F00Q14A ___(1)Yes ___(2)No
    b. Neonatal Jaundice: F00Q14B ___(1)Yes ___(2)No
    c. Hepatitis: F00Q14C ___(1)Yes ___(2)No

CLINICAL CENTER PHYSICIAN (to whom results will be reported):

15. Name: Never Entered
    (Last) (First) (MI)
16. Address: _____
    (Street)
    _____ _____ _____
    (City) (State) (Zip)
    _____ _____
    (Area Code) (Phone Number)

Form Completed by: _____