# Ambulatory Care Visit (2012)

Participant ID _____
((do not change this value))

OMB Number (0915-XXXX) Expiration date (XX/XX/20XX)

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Team site:
- ☐ Team 1 - Site A
- ☐ Team 1 - Site B
- ☐ Team 1 - Site C
- ☐ Team 1 - Site D
- ☐ Team 1 - Site E

Reviewer's initials: _____

Date of chart review: _____

What visit occurred this month? ☐ Heme ☐ PCP ☐ Both

Date of hematology visit: _____

Date of PCP visit: _____

Is the patient less than one year old? ☐ Yes ☐ No

Age in months at time of visit: (0 for under 1 month): _____
(number between 0 and 11)

Age in years at time of visit: _____
(number)

How many times was the patient seen in Day Hospital or Infusion Center in the past 12 months? _____
(hospitalization for management of an illness related or possibly related to sickle cell disease)

How many times was the patient seen in the Emergency Department during the past 12 months? _____
(hospitalization for management of an illness related or possibly related to sickle cell disease)

How many times was the patient admitted to the hospital in the past 12 months for sickle cell related illnesses? _____

## Care Coordination

Does the SCD patient have a documented primary care provider? ☐ Yes ☐ No ☐ Not available

In the past 12 months, has the patient had a visit with their PCP? ☐ Yes ☐ No ☐ Not available

Does the patient have a care manager? ☐ Yes ☐ No ☐ Not available

In the past 12 months, has the patient had evaluation with a hematologist or sickle cell specialist? ☐ Yes ☐ No ☐ Not available

Date of last evaluation with a hematologist or sickle cell specialist: _____

Does the patient have a written transition plan? ☐ Yes ☐ No ☐ Not available

In the past 12 months, did the patient have a written individual care plan? ☐ Yes ☐ No ☐ Not available

Was the care plan reviewed with the patient during the current visit? ☐ Yes ☐ No ☐ Not available

## Immunization

Is the patient up to date for PCV7 / PCV13 vaccination? ☐ Yes ☐ No ☐ Not available

Is the patient up to date for PPV23/Pneumovax vaccination? ☐ Yes ☐ No ☐ Not available

Is the patient up to date for meningococcal (MCV4 or MPSV4) vaccination? ☐ Yes ☐ No ☐ Not available

Is the patient up to date for haemophilus influenza (HIB) vaccination? ☐ Yes ☐ No ☐ Not available

Did the patient receive a flu vaccine during the last flu season? ☐ Yes ☐ No ☐ Not available

Is the patient up to date for hepatitis B vaccination? ☐ Yes ☐ No ☐ Not available

_____
(not for data entry)

## Routine Health Screening

Did the patient have depression screening in the past 12 months? ☐ Yes ☐ No ☐ Not available

Depression screening date: _____

Did the patient have BP screening in the past 12 months? ☐ Yes ☐ No ☐ Not available

BP screening date: _____

Did patient have ophthalmologic (dilated retinal) exam in the past 12 months? ☐ Yes ☐ No ☐ Not available

Ophthalmologic exam date: _____

## Transcranial Doppler Screening

Transcranial doppler screen in past 12 months? ☐ Yes ☐ No ☐ Not available

Date of last TCD: _____

Did the patient have at least 1 abnormal TCD in the past 12 months? ☐ Yes ☐ No ☐ Not available

Did the patient have a repeat TCD within 2 months of the abnormal TCD study? ☐ Yes ☐ No ☐ Not available

Did the patient have 2 consecutive abnormal TCDs in the past 12 months? ☐ Yes ☐ No ☐ Not available

## Transfusion Care

On transfusion protocol? ☐ Yes ☐ No ☐ Not available

Start Date: _____

Has the patient been assessed for iron overload in the past 12 months? ☐ Yes ☐ No ☐ Not available

Assessment date: _____

Does the patient currently have iron overload? ☐ Yes ☐ No ☐ Not available

Is the patient currently on chelation therapy? ☐ Yes ☐ No ☐ Not available

Chelation therapy start date: _____
(leave blank if not available)

What medication is the patient using for chelation therapy?

☐ Desferoxamine (Desferal)
☐ Deferasirox (Exjade)
☐ Deferiprone (Ferriprox)
☐ No meds taken

## Hydroxyurea

In the past 12 months, has the patient's medical record been reviewed to determine if they are a potential candidate for Hydroxyurea use? ☐ Yes ☐ No ☐ Not available

Date of last assessment: _____

Is patient candidate for hydroxyurea? ☐ Yes ☐ No ☐ Not available

Is the patient currently on hydroxyurea? ☐ Yes ☐ No ☐ Not available