

**Prussian Blue  
Patient Treatment Data Form**

**Send to: Heyltex Registry Center  
Facsimile (toll free): 1-877-496-3329  
Telephone (toll free): 1-866-439-5839 (1-866-HEYLTEX)**

<b>Date of report:</b> _____	<b>Unique patient identifier:</b> _____
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**Patient ID**

Name: _____ Date of birth: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address: _____
Phone: (_____) _____ Hospitalization: <input type="checkbox"/> No <input type="checkbox"/> Yes Where? _____

**Criteria for Diagnosis**

Date/time of exposure: _____
Geographic location/details of exposure: _____
<input type="checkbox"/> Lab/field confirmed exposure; method: _____
<input type="checkbox"/> Symptoms of Acute Radiation Syndrome: _____

**Contamination**

Radionuclide(s): <input type="checkbox"/> confirmed <input type="checkbox"/> suspected; list isotope(s): _____
Route (check all that apply): <input type="checkbox"/> Skin <input type="checkbox"/> Inhalation <input type="checkbox"/> Wound <input type="checkbox"/> Burn <input type="checkbox"/> Ingestion
Anatomic area affected: _____
Initial radioactivity measurement: _____
How measured: _____

**Decontamination**

External: <input type="checkbox"/> Skin washed with: _____
<input type="checkbox"/> Wound excised/washed: _____
Internal:
<input type="checkbox"/> Prussian blue Date/time of initial dose: ____/____/____ Amount: _____ Total doses: _____

**Adverse Reaction to Treatment**

Adverse Reaction(s) to treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes; provide details: _____
Vital signs: Baseline <input type="checkbox"/> Stable <input type="checkbox"/> Unstable: _____
Subsequent (if abnormal): _____
Disposition of patient/outcome of treatment: _____

**Treatment Team Data**

Report completed by: _____ Title: _____
Organization/affiliation: _____
Phone: (_____) _____ Email: _____@_____

**Comments**




## Pre/Post Treatment Data

### Labs

#### Electrolytes

#### CBC

#### LFT

	Na	K	Cl	HCO <sub>3</sub>	BUN	Cr	Glu	WBC	RBC	Plts	Hgb	HCT	AST	ALT
Pre														
Post														

#### Urine

#### Other

	Ur SG	Ur pH	Ur Pro	Ur Glu	Ur Ket	Ur Bld	Ur Nit	Ur Bil	Ur LE	Zn	Mg			
Pre														
Post														

**Other Clinical Data:**

**Bioassay Data:**

<b>Date/Time</b>	<b>Sample* (include volume/weight)</b>	<b>Radio- Nuclide #1</b>	<b>Activity Measure</b>	<b>Radio- Nuclide #2</b>	<b>Activity Measure</b>

<b>Date/Time</b>	<b>Sample* (include volume/weight)</b>	<b>Radio- Nuclide #1</b>	<b>Activity Measure</b>	<b>Radio- Nuclide #2</b>	<b>Activity Measure</b>

\*Sample type: urine, stool, blood, etc.

**Treatment Team Data:**

<b>Name</b>	<b>Signature</b>	<b>Date</b>
<b>Organization/affiliation:</b>		