Medical Record Document

STEM CELL TRANSPLANT PATIENT WORK UP ASSESSMENT

Setting: BRHC, BHOC
Patients: Adult and Paediatric Stem Cell Transplant
For use by: Nursing and Medical Staff

Trust no. _____
NHS no. _____
Surname _____
Forename(s) _____
Gender _____ D.o.B. ___/___/_____

PATIENT DETAILS:

Diagnosis:	Type of transplant:
Provisional Day 0:	Admission Date:

DONOR DETAILS:

If related: Trust no. _____ NHS no. _____ Surname _____ Forename(s) _____ Gender _____ D.o.B. ___/___/_____	**If unrelated:** Number/panel/ number:

WORK UP DETAILS:

	DATE		DATE
BMT consultation		Chest X-ray	
ECHO		Medical assessment	
Respiratory function		Nursing assessment	
TBI planning		BMT co-ordinator	
Dental check		Chest / sinus CT	
ECG		Disease status:	
Line insertion Details:	YES / NO	Back up BMH: Details:	YES / NO

NURSING ASSESSMENT:

Weight (kg)		Height (cm)		Urinalysis			
B / P		Pulse		Resps		Temp	
Workup bloods taken?	YES / NO & reason:						
Signed				Date			

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MEDICAL ASSESSMENT:

Review of Systems: Please ring "Yes" or "No" as appropriate

Fever	Yes	No	Haematuria	Yes	No
Sweats	Yes	No	Dysuria	Yes	No
Weight loss	Yes	No	Fits	Yes	No
Chest pain	Yes	No	Faint	Yes	No
Palpitations	Yes	No	Headache	Yes	No
SOBOE	Yes	No	Visual problems	Yes	No
Cough	Yes	No	Back pain	Yes	No
Abdo pain	Yes	No	Joint pain	Yes	No
Change in bowel habit	Yes	No	Smoker:	Yes ...../day	No
Nocturia	Yes	No	Alcohol:	.....Units/week	

Previous Medical History: (give any relevant details at end)

Asthma	Yes	No	Rheumatic Fever	Yes	No
Jaundice	Yes	No	Previous operations	Yes	No
Hypertension	Yes	No	Travel out of Europe (within last year)	Yes	No
GA	Yes	No			
PH TB	Yes	No	Malaria risk	Yes	No
Epilepsy	Yes	No	Hep B vaccine	Yes	No
Other:			Previous transfusions	Yes	No

Relevant family history:

Currently attending (or waiting to see) GP / Specialist Consultant? NO / YES & details:

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Current medication:

Allergies: No / Yes & details:	**Previous GCSF / other Cytokine:** No / Yes & details:

General examination: Normal / Abnormal

State Abnormality:

Hepatomegaly	No / Yes If yes, size:	**Splenomegaly**	No / Yes If yes, size:

Reproductive history:

Parity (G&P) (&)	Breast feeding? Yes / No	Contraception? Yes / No
Details:		
LMP:	Possibility of pregnancy? YES / NO	Pregnancy test: POS / NEG

Medical assessment undertaken by (Print Name):

Signature:

Date:

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WORK-UP INVESTIGATION RESULTS:

ECG	
Echo	
Respiratory function	
Dental check	
CXR	
Bone age	
Chest / Sinus CT	
Karnofsky scale	
ABO and Rh Genotype	
Blood test results:	PLEASE REFER TO ICE REPORT

Patient fit for transplant?	Yes No If no, reason for failure:
Comments:	

Signed			
Print name and Designation		Date	