

25. INTERNAL CONTAMINATION SUSPECTED?

No Yes Unk.

26. WAS A DOSE ESTIMATION CALCULATED FOR THE PATIENT? (if yes, indicate the method used and dose)

No Yes Unk.

26a. DOSE ESTIMATION METHOD USED?

- Chromosome analysis (dicentrics) Prodromal symptoms
- Dose reconstruction Time to onset of vomiting
- Lymphocyte depletion kinetics _____

26b. DOSE ESTIMATION?

Gy

SECTION 4: MEDICAL HISTORY AND TREATMENT INFORMATION

27. COMORBIDITIES

- Alzheimer's / dementia COPD / pulmonary fibrosis Intellectual disability Seizures Thyroid disease
- Atrial fibrillation / atrial flutter Coronary artery disease Leukemia / lymphoma Sickle cell disease _____
- Asthma Diabetes Liver disease Sickle cell trait _____
- Autoimmune disease Hepatitis Mental health illness Solid tumor / cancer _____
- BMI > 30 HIV / AIDS Organ transplant Stroke None
- Chronic kidney disease Hypertension Physical disability Thrombotic disease Unk.

28. PATIENT ADMISSION STATUS

- Inpatient (If checked, please specify the bed type below)
BED TYPE
 General Hematology/Oncology Palliative Burn ICU Observation
- Outpatient
- No follow-up required

29. TRAUMATIC INJURY (if yes, please specify the region below)

- No Yes Unk.
- TRAUMA REGIONS (check all that apply)
 head / neck face thorax abdomen / pelvis extremities external
- Injury Severity Score (link to ISS calculator: <https://www.mdcalc.com/injury-severity-score-iss>)
 Unk.

30. THERMAL BURNS (if yes, please specify degree and BSA % below)

- No Yes Unk.
- BURN(S) DEGREE (check all that apply)
 1st degree 2nd degree 3rd degree
- BURN SURFACE AREA %
 <5% 6-10% 11-20% 21-30% 31-40% >41%

31. INFECTION COMPLICATIONS (check all that apply)

- Pneumonia Sepsis Skin infection ENT infection Colitis UTI
- _____ None Unk.

32. NEUTROPENIA

No Yes Unk.

33. GI BLEED

No Yes Unk.

34. CUTANEOUS RADIATION INJURY (erythema or edema)

No Yes Unk.

35. CBC LABORATORY DATA

	MONTH	DAY	YEAR	TIME (24hrs)	WBC ($\times 10^9/L$)	HGB (mmol/L)	PLATELETS ($\times 10^9/L$)	ABS LYMPH ($\times 10^9/L$)
a.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
b.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
e.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
f.	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

36. ACUTE RADIATION SYNRDROME (ARS) DIAGNOSIS (If yes, indicate the sub-syndrome below)

No Yes Unk.

ARS SUB-SYNDROME

Hematologic Gastrointestinal Cutaneous Neurovascular Unk.

37. COLONY STIMULATING FACTORS ADMINISTIERED

	No Yes Unk.			CYTOKINE	STARTED		STOPPED		DOSE GIVEN (include units)
	MONTH	DAY	MONTH		DAY				
a.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FILGRASTIM	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
b.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PEGFILGRASTIM	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
c.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SARGRAMOSTIM	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
d.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ROMIPLOSTIM	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____
e.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	_____

38. COMPLICATIONS FROM COLONY STIMULATING FACTORS USE? (check all that apply)

Bone pain Splenic rupture Acute Respiratory Distress Syndrome Leukocytosis ($>11\text{kmm}^3$)
 Infusion/injection site reaction Systemic allergic reaction Serosal Effusions/Capillary Leak Syndrome
 Sickle cell crisis None Unk.

39. BLOOD PRODUCTS (check all that apply)

Platelets Plasma RBCs _____ None Unk.

40. MEDICATION USE

MEDICATION CODE	STARTED		STOPPED		CODE	MEDICATION
	MONTH	DAY	MONTH	DAY		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	01	Doxycycline
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	02	Ciprofloxacin
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	03	Levofloxacin
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	04	Metronidazole
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	05	Trimethoprin/Sulfamethoxazole
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	06	Clindamycin
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	07	Ceftriaxone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	08	Vancomycin
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	09	Ampicillin/Sulbactam
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	10	Piperacillin/Tazobactam
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	11	Fluconazole
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	12	Amphotericin
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	13	Caspofungin
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	14	Acyclovir
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	15	Diflucan
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	16	Antiemetics (Ondansetron, Granisetron, Metochlopramide, others)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	17	Analgesics (non-opioid, NSAIDS, Acetaminophen)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	18	Opioids
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	19	Antidiarrheals (Loperamide, Diphenoxylate, others)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	20	_____
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	21	_____
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	22	_____
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	23	_____
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	24	_____

SECTION 5: PATIENT OUTCOME

41. DISPOSITION STATUS & ASSOCIATED ICD-10 DIAGNOSIS CODE(S)

	MONTH	DAY	YEAR	ICD-10 Diagnosis code(s):	
<input type="checkbox"/> In progress	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Transferred	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Discharged	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="checkbox"/> Deceased	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>