Severe Chronic Neutropenia International Registry

1107 NE 45th Street, Suite 345
Seattle, WA 98105
Phone 206-543-9749 Fax 206-543-3668

Patient's Full Name: _____

DOB: _____ / _____ / _____ Patient's ID #:_____
Month / Day / Year

Malignancies and Hematological Complications

Please attach all pertinent pathology and laboratory reports.

Patient's Living Status

☐ **Alive** - Last Contact Date ____/____/_____
Month / Day / Year

☐ **Deceased** - Date of Death ____/____/_____
Month / Day / Year

Cause of Death_____

Non-Myeloid Malignancies

☐ **Skin Cancer**

☐ Basal Cell Diagnosis Date ____/____/_____
Month / Day / Year

☐ Squamous Cell Diagnosis Date ____/____/_____
Month / Day / Year

☐ Melanoma Diagnosis Date ____/____/_____
Month / Day / Year

☐ Other Diagnosis Date ____/____/_____
Month / Day / Year

Description _____

☐ **Bladder Cancer** Diagnosis Date ____/____/_____

☐ **Colon Cancer** Diagnosis Date ____/____/_____

☐ **Lung Cancer** Diagnosis Date ____/____/_____

☐ **Pancreatic Cancer** Diagnosis Date ____/____/_____

☐ **Sarcoma** Diagnosis Date ____/____/_____

Description _____

_____

☐ **Breast Cancer** Diagnosis Date ____/____/_____

☐ **Liver Cancer** Diagnosis Date ____/____/_____

☐ **Ovarian Cancer** Diagnosis Date ____/____/_____

☐ **Prostate Cancer** Diagnosis Date ____/____/_____

☐ **Thyroid Cancer** Diagnosis Date ____/____/_____

☐ **Other** *(specify below)*: Diagnosis Date ____/____/_____

_____

Hematological Complications

☐ **Cytogenetic Changes** Diagnosis Date ____/____/_____
Month / Day / Year

☐ **Monosomy 7** Diagnosis Date ____/____/_____

☐ **Myelodysplastic Syndrome**
Diagnosis Date ____/____/_____

☐ **Acute Myeloid Leukemia**
Diagnosis Date ____/____/_____

☐ **Myelofibrosis** Diagnosis Date ____/____/_____
Month / Day / Year

☐ **Aplastic Anemia** Diagnosis Date ____/____/_____

☐ **Other** *(specify below)*: Diagnosis Date ____/____/_____

_____

☐ **Other** *(specify below)*: Diagnosis Date ____/____/_____

_____

Other Complications

☐ **ALL (**Acute Lymphoblastic Leukemia**)** Diagnosis Date ____/____/_____
Month / Day / Year

☐ **Lymphoma** Diagnosis Date ____/____/_____
Month / Day / Year

☐ **CLL (**Chronic Lymphocytic Leukemia**)** Diagnosis Date ____/____/_____

☐ **Other** *(specify below)*: Diagnosis Date____/____/_____

_____

☐ **Lymphoproliferative Disorder** Diagnosis Date____/____/_____

☐ T-Cell Diagnosis Date____/____/_____

☐ Natural Killer Cell Diagnosis Date____/____/_____

☐ **LGL (**Large Granular Lymphocytes**)** Diagnosis Date____/____/_____

☐ **LGLL (**Large Granular Lymphocytic Leukemia**)** Diagnosis Date____/____/_____

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Please use the back of this form or attach an extra page to provide any additional information if this side of page is not sufficient.