

NAME OF ADMINISTERING CENTRE:

1 YEAR FOLLOW-UP FORM-5

(Please Print)

Surgeon (primary):		Hospital:		Hospital medical number: (URL)	
Patient's last name:	First:	Middle:			

Instructions:

Surgeons are responsible for ensuring all the required information on this form is as complete and accurate as possible. The completed form should be forwarded to the State Coordinator, who must check for any omissions prior to sending the form to the EVAR Project Data Manager:

Data Manager, EVAR Project
Basil Hetzel Institute
28 Woodville Road
DX465702
Woodville South, SA 5011
T: 61 8 8133 4015
F. 61 8 8222 7872
E: evartrial@adelaide.edu.au

- On receipt of this form in Adelaide, the Data Manager will add the same de-identifying code previously allocated to this patient. The code must be added to each page of the form (top right hand corner).
- This page, where patient name and address are provided, will be physically separated from the rest of the form and stored separately to the EVAR data.
- For the duration of the research project only the Data Manager and Principal Investigator are permitted to re-identify patient forms, and only where this is necessary for obtaining follow-up information or for quality assurance purposes.

1 YEAR FOLLOW-UP FORM

(Please print) ***Blood/biomarker at pre-op, 6 months post-op, 3 years post-op and at reintervention**

Surgeon responsible for follow-up:																			
Patient status: Alive <input type="checkbox"/>				Deceased <input type="checkbox"/>				Cause of death:											
Date of death:		/		/															
Date of examination:				/		/													
FOLLOW-UP EVALUATION																			
Imaging technique:		Spiral CT		Yes <input type="checkbox"/>		No <input type="checkbox"/>		MRI		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Ultrasound		Yes <input type="checkbox"/>		No <input type="checkbox"/>	
		Abdominal x-ray		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Other		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Type:					
DICOM copies of CT scans made:				Yes <input type="checkbox"/>		No <input type="checkbox"/>													
IMAGING RESULTS																			
Size of aneurysm:		(mm)																	
Normal findings		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Endoleak		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Type I <input type="checkbox"/>		Type II <input type="checkbox"/>		Type III <input type="checkbox"/>		Type IV <input type="checkbox"/>							
Kinking		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Migration		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Distance (mm):													
Graft infection		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Graft thrombosis		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Stenosis		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Broken or damaged wires		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Other graft complication		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Describe:													
SURGICAL INTERVENTIONS *take blood/biomarker samples at time of reintervention (see below for additional information)																			
Has the patient required any interventions for the aneurysm since being discharged from hospital?										Yes <input type="checkbox"/>		No <input type="checkbox"/>							
Reason for reoperation:																			
Bleeding		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Endoleak		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Rupture		Yes <input type="checkbox"/>		No <input type="checkbox"/>															
Other cause		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Describe:													
Type of intervention:																			
Open		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Date of operation:		/		/									
Details:																			
Endovascular		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Date of operation:		/		/									
Details:																			
Other		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Date of operation:		/		/									
Details:																			
MEDICATION (tick one)																			
B blocker		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Statin use		Yes <input type="checkbox"/>		No <input type="checkbox"/>		Warfarin		Yes <input type="checkbox"/>		No <input type="checkbox"/>			

ADDITIONAL INFORMATION REQUIRED AT REINTERVENTION					
White cell count – total:	(x10 ⁹ /L)	Creatinine:	(µmol/L)	Urea:	(mmol/L)
Sodium:	(mmol/L)	Potassium:	(mmol/L)		
BIOMARKERS COLLECTED: Yes <input type="checkbox"/> No <input type="checkbox"/>		<p>If yes – please provide results for the following tests performed at your local pathology laboratories.</p> <p>If yes – please ensure you also collect the following samples for additional biomarker processing in Townsville: serum (10ml), plasma (10ml) and genotyping (4ml). Samples should be stored at -70C prior to transporting in batches.</p>			
Lipids:	Total serum cholesterol:	(mmol/L)	Triglycerides:	(mmol/L)	
	HDL:	(mmol/L)	LDL:	(mmol/L)	
CRP:	(mg/l)	Plasma fibrinogen:	(g/l)	Homocysteine:	(µmol/L)