New England Newborn Screening Program
University of Massachusetts Medical School
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CENSUS SICKLE CELL DISEASE PATIENTS

Child's Name: _____
DOB: _____
NBS Result: _____
Confirmed Result: _____

Alive Y / N: If no, date:_____

Date of First Clinic Visit: _____
Date of Most Recent Clinic Visit: _____
Current Height/Weight **(NOT Percentile)**: Height:_____ Weight: _____

Clinical Stroke:
Y/N_____If yes, Date: _____

Radiological Stroke:
Y/N_____If yes, Date: _____

MRI/MRA:
Normal/Abnormal_____Date: _____

Culture + Bacturemia:
Febrile Episodes:_____Date(s): _____
Culture + Y/N_____Date: _____

TCD
First TCD: _____
Normal/Abnormal_____Date: _____

Hyper Transfustions (on going transfusions:
Start Date : _____
Stop Date : _____

Prescribed Hydroxyurea in Last 6 Months:
Start Date : _____
Stop Date : _____

Spleenectomy:
Y/N_____If yes, Date: _____

Hospitalizations:
Y/N_____If yes, Date(s): _____

Acute Chest*:
Y/N_____If yes, Date: _____

*per Consortium definition