RECORD ID: |___||___||___||___| |___|

CHILDHOOD LYMPHOMA REGISTRY FORM, LACOR HOSPITAL

COMPLETE THE FOLLOWING INFORMATION FOR EVERY NEW PATIENT ADMITTED TO THE LYMPHOMA ROOM, CHILDREN'S WARD

SECTION A: HISTORY

1. DATE OF ADMISSION: |___||___| / |___||___| / |___||___||___||___|
   DAY MONTH YEAR

2. INPATIENT'S NUMBER: |___||___||___||___||___||___||___||___| / |___||___||___||___|
   NUMBER YEAR

3. TYPE OF PATIENT: |___|NEW (***skip to Question 5***)
   |___|ON TREATMENT
   |___|RELAPSE

4. IF ***TREATMENT OR RELAPSED***,
   a. DATE FIRST DIAGNOSED: |___||___| / |___||___| / |___||___||___||___|
      DAY MONTH YEAR

   b. HEALTH UNIT: _____

SECTION B: DEMOGRAPHIC

5. PATIENT SURNAME: _____OTHER NAME: _____

6. PATIENT DATE OF BIRTH: |___||___| / |___||___| / |___||___||___||___| OR AGE: |___||___|
   DAY MONTH YEAR

7. PATIENT'S GENDER: |___|MALE |___|FEMALE

8. PATIENT'S TRIBE: _____

9. MOTHER'S SURNAME: _____OTHER NAMES: _____

10. FATHER'S SURNAME: _____OTHER NAMES: _____

11. GUARDIAN'S SURNAME: _____OTHER NAMES: _____

12. RESIDENCE OF THE FAMILY (where child usually lives):

LCI/Village: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

LCII/Parish: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Sub-county: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

County: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

District: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Country: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

TELEPHONE: |___|___|___|___|___|___|___|___|___|___|/ |___|___|___|___|___|___|___|___|___|___|

Description of address:

SECTION C: SYMPTOMS AND SIGNS

13. PRESENT SYMPTOMS (***Tick all that apply***)
|___| Fever
|___| Weight loss
|___| Excessive sweating
|___| Body part swelling
|___| Yellow eyes
|___| Bone pain
|___| Bleeding
|___| Inability to use one or more limbs
|___| Others (specify) _____

14. TIME SINCE ONSET OF FIRST SYMPTOMS: |___| < 1 Months
|___| 1 -2 Months
|___| 3-4 Months
|___| > 4 Months

15. WAS THE CHILD LIVING AT THE SAME ADDRESS AS HE/SHE DOES NOW (as recorded in **Question 9 Form #1) FOUR** MONTHS PRIOR TO THE ONSET OF SYMPTOMS?

|___|YES (***Skip to Question 17***) |___|NO

IF ***NO***:
a. AT WHAT ADDRESS WAS THE CHILD LIVING WHEN THE SYMPTOMS FIRST BEGAN?

Village/Local council:	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Parish:	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Sub-county:	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
County:	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
District:	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Country:	|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|
Description of address:	

16. HOW LONG WAS THE CHILD LIVING AT THIS ADDRESS? |___|___| |___|___|
YEARS MONTHS

SECTION D: ANATOMICAL SITES

17. MAIN ANATOMICAL SITE(S) AFFECTED (Select ALL that apply:

Anatomic site	***Affected side*** Left	Right
a. Lymph node swelling	|___|Cervical (Left)	|___|Cervical (Right)
	|___|Axiliary (Left)	|___|Axiliary (Right)
	|___|Inguinal (Left)	|___|Inguinal (Right)
b. Maxilla swelling	|___| Left	|___| Right
c. Mandible swelling	|___| Left	|___|Right
d. Proptosis/Eye swelling	|___| Left	|___|Right
e. Abdominal swelling	|___|	
f. other swellings, specify	_____	

18. ORGANS INVOLVED (PHYSICAL EXAM AND RADIOLOGY)(Select ALL that apply:

ORGAN				
a.	Cranial nerve	|___| Left	|___|Right	Specify level:_____
b.	Kidney	|___| Left	|___|Right	
c.	Ovaries	|___| Left	|___|Right	
d.	Paraplegia or Paraperesis	|___|		
e.	Incontinence (stool/urine)	|___|		
f.	Spleen	|___|		
g.	Liver	|___|		
h.	Lungs/Pleura	|___|		
i.	Mediastinum masses	|___|		
j.	Bowel	|___|		
k.	Pancreas	|___|		
l.	Others, specify	_____		

SECTION E: CONFIRMATION OF DIAGNOSIS

19. A) METHOD OF CONFIRMATION OF BL DIAGNOSIS? |___|BIOPSY
|___|CLINICAL

IF BIOPSY,

a. DATE OF BIOPSY: |___||___| / |___||___| / |___||___||___||___|
DAY MONTH YEAR

b. BIOPSY PERFORMED AT: _____

c. BIOPSY NUMBER: |___|___|___|___|___|___|___|___|___|___|___|___|

d. TYPE OF BIOPSY: |___|INCISION/EXCISION
|___|FINE NEEDLE ASPIRATION
|___|TRUCUT BIOPSY

IF CLINICAL,

a. DATE OF CLINICAL DIAGNOSIS: |___||___| / |___||___| / |___||___||___||___|
DAY MONTH YEAR

B) CANCER DIAGNOSIS: _____

20. C.S.F CYTOLOGY RESULTS: |___|NOT DONE
|___|NEGATIVE FOR MALIGNANT CELLS
|___|POSITIVE FOR MALIGNANT CELLS

21. BONE MARROW RESULTS: |___|NOT DONE
|___|NEGATIVE FOR MALIGNANT CELLS
|___|POSITIVE FOR MALIGNANT CELLS

22. HIV SEROLOGY: |___|NOT DONE
|___|NEGATIVE
|___|POSITIVE

23. LIST OTHER DIAGNOSES:

a. _____
b. _____
c. _____

FORM FILLED BY: _____ DATE: _____

NAME OF ENTRANT INTO COMPUTER: _____DATE: _____