**Small Bowel Summary**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Liver | [ ]  | Pancreas | [ ]  | Stomach | [ ]  | Duodenum | [ ]  |

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| **OSOTC Patient Number:** |       |

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| **PATIENT DEMOGRAPHICS** |
| **Initials:**       | **Birth Date:**       | **Height:**       |  **Weight:**       |  |
| **Gender:** M [ ]  F [ ]  | **ABO:** A [ ]  B [ ]  AB [ ]  O [ ]  | **Race:**       | **Transplant#:**       |  |

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| **PATIENT STATUS** |
| **MEDICAL DIAGNOSIS:**       | **MELD/PELD/Status:**       |
| **MEDICAL HISTORY** (Please indicate nutritional status, infection, ascites, variceal hemorrhage, encephalopathy, etc.):      |

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| **LABORATORY DATA** |
| **Renal** | Patient | Lab Date | Normal Range |
| BUN |       |       |       |
| Creatinine |       |       |       |
| **Hepatic** | Patient | Lab Date | Normal Range |
| AST (SGOT) |       |       |       |
| ALT (SGPT |       |       |       |
| Alk Phos |       |       |       |
| Amylase |       |       |       |
| T Bili |       |       |       |
| PTT |       |       |       |
| Albumin |       |       |       |
| INR |       |       |       |
| **Other** | Patient | Lab Date | Normal Range |
| WBC |       |       |       |
| HGB/HCT |       |       |       |
| Platelets |       |       |       |
| Calcium |       |       |       |
| Glucose |       |       |       |
| T Protein |       |       |       |
| Sodium |       |       |       |
| Potassium |       |       |       |
| Chloride |       |       |       |
| Ammonia |       |       |       |
| **Serology** | Patient | Lab Date | Normal Range |
| Anti HAV |       |       |       |
| HBsAg |       |       |       |
| Anti HBs |       |       |       |
|  HBeAg |       |       |       |
|  HBV DNA |       |       |       |
| Anti HBc |       |       |       |
|  Anti HBe |       |       |       |
| Anti HCV |       |       |       |
|  Method |       |       |       |
|  HCV RNA |       |       |       |
| CMV IGG |       |       |       |
| CMV IGM |       |       |       |
| HIV |       |       |       |

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| **Psychosocial Evaluation/Quality of Life**(Support system, informed consent, attitude about transplant, aftercare, complications, etc.): |
|       |

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| **Ohio Medicaid Insurance**The Ohio Medicaid Required Information Form should be submitted along with this summary. |
| **Select Type:**  | Standard Medicaid [ ]   | Medicaid Managed Care Plan [ ]   |