**Small Bowel Summary**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Liver |  | Pancreas |  | Stomach |  | Duodenum |  |

|  |  |
| --- | --- |
| **OSOTC Patient Number:** |  |

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **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.): |
|  |

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