Ca-DTPA
Patient treatment Data

Send to: hameln pharmaceuticals ltd, Nexus, Gloucester Business Park, Gloucester, GL3 4AG, United Kingdom

Date of report: **Unique patient identifier:**

Patient ID:

Name:_____ Date of birth_____ Sex: ☐ Male ☐ Female

Address:_____

Phone:(_____)_____ Hospilization: ☐ No ☐ Yes Where?_____

Criteria for Diagnosis

Date/time of exposure:_____

Geographic location/details of exposure:_____

☐ Lab/field confirmed exposure; method:_____

☐ Symptoms of Acute Radiation Syndrome:_____

Contamination

Transuranium element(s):☐ confirmed ☐ suspected, list element(s):_____

Route (check all that apply): ☐ Skin ☐ Inhalation ☐ Wound ☐ Burn ☐ Ingestion

Anatomic area affected:_____

Initial radioactivity measurement:_____

How measured:_____

Decontamination

External: ☐ Skin washed with:_____

☐ Wound excised/washed:_____

☐ Contraindications to aerosolized treatment

(h/o lung disease, cough, dyspnea, chest tightness, wheezing)?_____

_____

Internal:

☐ Ca-DTPA Date/time of initial dose:_____/_____ Amount:_____ Total doses:_____ Route:_____

Adverse Reaction to Treatment:

Adverse Reaction(s) to treatment? ☐ No ☐ Yes, provide details:_____

_____

Vital signs: Baseline ☐ Stable ☐ Unstable:_____

Subsequent (if abnormal):

Disposition of patient/outcome of treatment:_____

Treatment Team data

Report completed by:_____ Title:_____

Organization/affiliation:_____

Phone:(_____)_____ Email:_____@_____

Comments:

_____

_____

_____

Attach Copy of Emergency Records to this Form