

YHHN Data Collection: Hairy cell leukaemia

Please enter data into boxes, and amend any incorrect or missing details:

Patient Name:

HILIS ID:

Date of Birth:

NHS No:

HMDS Number:

Report Date:

Source:

Specimen:

Demographics:

Gender:	M / F	Date of diagnosis:	
Address at diagnosis:			
GP address:			
1st appointment on:		Palliative date:	
Date of death:			

Antecedent / concurrent events:

Event:	
Therapies:	chemotherapy / radiotherapy / both

Treatment history:

Centre:	[name]				
Treatment:	[treatment name]				
Trial:	[trial name]				
Start date:		End date:		Response:	

Presentation data:

ECOG:	[0 - 4]	Hb:	[g/dL]
BM biopsy:	[Y/N]	WBC:	[x10 ⁹ /L]
Sweats:	[Y/N]	Lymphs:	[x10 ⁹ /L]
Fever:	[Y/N]	Albumin:	[g/L]
Wt. loss:	[Y/N]	β₂m:	[mg/L]
CT Scan:	[Y/N]	LDH:	[range]
Ann-Arbor:	[I - IV]		

Nodal involvement:

Site	L R
Waldeyer's ring:	<input type="checkbox"/>
Neck:	<input type="checkbox"/> <input type="checkbox"/>
Infraclavicular:	<input type="checkbox"/> <input type="checkbox"/>
Axillary/pectoral:	<input type="checkbox"/> <input type="checkbox"/>
Arm:	<input type="checkbox"/> <input type="checkbox"/>
Thymus:	<input type="checkbox"/>
Hilar:	<input type="checkbox"/> <input type="checkbox"/>
Mediastinal:	<input type="checkbox"/>
Para-aortic:	<input type="checkbox"/>
Spleen:	<input type="checkbox"/>
Mesenteric:	<input type="checkbox"/>
Iliac:	<input type="checkbox"/> <input type="checkbox"/>
Inguinal/femoral:	<input type="checkbox"/> <input type="checkbox"/>
Popliteal:	<input type="checkbox"/> <input type="checkbox"/>
Bulky disease:	<input type="checkbox"/>

Extranodal involvement:

Site	L R
Blood:	<input type="checkbox"/>
Bone:	<input type="checkbox"/>
CNS:	<input type="checkbox"/>
GIT:	<input type="checkbox"/>
GU:	<input type="checkbox"/>
Liver:	<input type="checkbox"/>
Marrow:	<input type="checkbox"/>
Muscle:	<input type="checkbox"/>
Orbit:	<input type="checkbox"/> <input type="checkbox"/>
Pericardium:	<input type="checkbox"/>
Pulmonary:	<input type="checkbox"/> <input type="checkbox"/>
Salivary gland:	<input type="checkbox"/> <input type="checkbox"/>
Skin:	<input type="checkbox"/>
Thyroid:	<input type="checkbox"/>
Other:	<input type="checkbox"/>
Extensive disease:	<input type="checkbox"/>

Comments: