**\*Study Number:       Date:**

**Local contact email:**

**Partnering with:**

**International Calciphylaxis Collaborative Network (ICCN)**

**Baseline Data Collection Form (from time of diagnosis)**

**(Please click on grey area for data input)**

|  |  |  |  |
| --- | --- | --- | --- |
| **1.** Has patient consent to study been obtained? | |  | |
| **2.** Race: | |  | |
| **3.** Approx date of first ever treatment for chronic kidney  disease e.g. dialysis or pre-emptive transplant: | | (dd/mm/yyyy) | |
| **4.** Indicate patient’s renal status at the time of first  symptoms of Calciphylaxis: | |  | |
| **5.** Previous RRT: (mark all applicable)  HD/HDF PD Tx | | | |
|  | | | |
| **6. Past Medical History:** | | | |
| Coronary heart disease / coronary artery disease | |  | |
| Myocardial infarction ever | |  | |
| Cerebrovascular disease / stroke | |  | |
| Peripheral vascular disease | |  | |
| Diabetes mellitus | |  | |
| Arterial hypertension | |  | |
| Bone fractures presumed related to CKD | |  | |
| Parathyroid surgery (PTx)  If yes, please give approx date: | | (dd/mm/yyyy) | |
| Did Reimplantation occur? | |  | |
|  | | | |
| **7. Laboratory data:**  Enter the lab values at diagnosis (pre dialysis if appropriate) and please indicate the  units in star fields \*: | | | |
| **Test name** | **Value** | | **Unit** |
| Creatinine |  | | µmol/L |
| Calcium (total) |  | | mmol/L |
| Corrected Calcium |  | | mmol/L |
| Phosphate |  | | mmol/L |
| Total protein |  | | g/L |
| Albumin |  | | g/L |
| Alkaline phosphatase (total) |  | | U/L |
| Intact PTH (iPTH) |  | | \* |
| Or Bioactive PTH |  | | \* |
| CRP |  | | mg/L |
| Haemoglobin |  | | \* |

|  |  |
| --- | --- |
| **8. Dialysis Prescription & Delivered Dose:** | |
| **Haemodialysis:** | |
| Prescribed length of treatment  e.g. Minutes: 240  Sessions /week: 3 | Minutes:  Sessions / week: |
| Blood Urea Reduction Ratio  (most recent value prior to onset of  calciphylaxis)    or Kt/V |  |
| Dialysate calcium concentration |  |
|  |  |
| **Peritoneal dialysis:** | |
| Which therapy is the patient receiving? |  |
| Dialysis fluid volume per 24h |  |
| Total weekly Creatinine clearance    or Total weekly Kt/V urea |  |
|  | |
| **9. Renal medications at time of diagnosis:** | |
| Vitamin D: |  |
| Intravenous route: |  |
| Drug name: |  |
| e.g. calcitriol 1 microgram x 3/week for 2 months. | Dose:       Unit: |
| Frequency:      / |
| Duration: |
|  | |
| Phosphate binders: |  |
| Drug name: |  |
| e.g. calcium carbonate 1.25g TDS for 3 months. | Dose:      Unit: |
| Frequency: |
| Duration: |
| **And** | |
| Drug name: |  |
| e.g. sevelamer 1.6g (i.e. 800mgx2) TDS for  4 months. | Dose:       Unit: |
| Frequency: |
| Duration: |
|  | |
| Calcimimetics: |  |
| Drug name: |  |
| e.g. Cinacalcet 90mg OD for 6 months. | Dose:      Unit: |
| Frequency: |
| Duration: |
|  | |

|  |  |  |  |
| --- | --- | --- | --- |
| Vitamin K antagonists (e.g. Coumarin): |  | | |
| -If yes – indication e.g. AF |  | | |
|  |  | | |
| ACE-inhibitors/ARBs |  | | |
|  |  | | |
| Erythropoetins / ESA |  | | |
|  | | | |
| **10. Calciphylaxis details:** | | | |
| a. Date of onset of first lesions: | | (dd/mm/yyyy) | |
| b. Potentially contributing event at site of lesion: | |  | |
| If yes, indicate the event: | |  | |
| c. Time from onset of symptoms to diagnosis: | | day(s) | |
| d. Diagnosis made by (tick all that apply) : | | | |
| clinical impression wound (pls use wound assessment tool)  skin biopsy taken?  radiograph of soft tissue nuclear medicine “bone” scan  transcutaneous oxygen assessment  pain scale (1-10)      other (please give brief explanation) | | | |
| e. Location of lesions: | | | |
| abdomen thighs buttock  penis / vulvar area breasts lower extremities (calves, legs)  feet / toes back arms  hands / fingers other | | | |
| f. Size of the wound (cm): | | | |
| g. Were there any known hypercalcaemia in 6 months  prior to onset of symptoms | | |  |
| If yes,  what was maximum recorded serum corrected calcium:  contemporaneous phosphate/PTH: | | | / |

|  |  |
| --- | --- |
| ***END of Baseline Data Collection Form*** | |
| ***Thank you very much for submitting your patient details to EuCalNet.***  ***PLEASE ENSURE THE STUDY NUMBER HAS BEEN ENTERED ON PAGE ONE.*** | |
| Please fax the form to **+49 3576287944** | For any questions please email hrothe@moldiag.de |
| You will receive a reminder for follow up data collection in 4 weeks time. | |