**\*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. |