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REGISTRATION FORM – fax to 03 9076 2431

Victorian Spleen Registry (VSR) based at The Alfred hospital
 2nd Floor Burnet Building, 85 Commercial Road, Melbourne 3004
 email: spleenregistry@alfred.org.au

1. **DATE** / /
2. Medicare No: -
3. Indication for referral
 Splenectomy Splenic embolisation
 Spleen damaged Hyposplenism
 Other
4. **Date of splenectomy** / /
5. Reason for splenectomy
 Trauma (**describe**) Incidental
 Haem disorder (**specify**) Haematological malignancy
 Cancer (**specify**) Other
6. **Surgeon's name:** **6a. Hospital** where splenectomy performed
7. Allergic to any antibiotics? **yes** **no** if YES, which antibiotic
8. Allergic to any vaccines? **yes** **no** if YES, which vaccine

PATIENT'S HOSPITAL STICKER or complete by hand

Hospital record number
 Full name
 Address
 Suburb & postcode
 State **Home phone**
DATE OF BIRTH ____ / ____ / ____

MUST BE COMPLETED

Patient's **Mobile**
 Patient's **Email**
Contact number of person NOT LIVING WITH PATIENT (can be a friend or relative)
 Second contact ph.
 Name at second no

9. Vaccination History	Date last received	Given today	Next due (year)
Pneumococcal polysaccharide <i>(eg. Pneumovax 23)</i>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="text"/> <input type="text"/> <input type="text"/>
Meningococcal C conjugate <i>(eg. Menjugate, Meningitec, NeisVac-C)</i>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no	Only one dose required
Meningococcal polysaccharide <i>(eg. Mencevax ACWY)</i>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="text"/> <input type="text"/> <input type="text"/>
Haemophilus influenzae type b <i>(Liquid Pedvax or Hiberix)</i>	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no	Only one dose required
Influenza Vaccine (annual - administered March to end of August)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="text"/> <input type="text"/> <input type="text"/>
Other pneumococcal vaccinations Pneumococcal conjugate (eg. Prevenar)	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		

10. Prophylactic Antibiotics	<input type="checkbox"/> yes <input type="checkbox"/> no	What was prescribed? <input type="checkbox"/> Penicillin <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Roxithromycin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Other (please specify) DOSE <input type="text"/> <input type="text"/> <input type="text"/> mg FREQUENCY <input type="checkbox"/> times per day DURATION recommended? <input type="checkbox"/> 2 years <input type="checkbox"/> Lifelong <input type="checkbox"/> Other (please specify)									
11. Emergency supply of antibiotics (eg. Amoxil 3gm dose) patient to seek medical attention after taking	<input type="checkbox"/> yes <input type="checkbox"/> no	What was prescribed? <input type="checkbox"/> Penicillin <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Roxithromycin <input type="checkbox"/> Other (please specify) STAT DOSE <input type="text"/> <input type="text"/> <input type="text"/> g / mg									
12. Has patient received an Education session (↑ risk of infection)	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> patient only <input type="checkbox"/> patient & accompanying person <input type="checkbox"/> education kit given/sent <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>									
13. Since splenectomy has there been an episode of		<table border="1"> <thead> <tr> <th>YEAR</th> <th>Hospital</th> <th>Treatment details</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td><input type="text"/> <input type="text"/> <input type="text"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/> yes <input type="checkbox"/> no</td> <td><input type="text"/> <input type="text"/> <input type="text"/></td> <td></td> </tr> </tbody> </table>	YEAR	Hospital	Treatment details	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="text"/> <input type="text"/> <input type="text"/>		<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="text"/> <input type="text"/> <input type="text"/>	
YEAR	Hospital	Treatment details									
<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="text"/> <input type="text"/> <input type="text"/>										
<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="text"/> <input type="text"/> <input type="text"/>										

GP Name Address Email
 Suburb Postcode State Phone number

Has this patient been informed that their information will be forwarded to the Vic Spleen Registry **yes** **no**

Additional information
PRINT name of person filling in this form phone no/pager