



---

---

**PATIENT INFORMATION**

**Past Medical History (PMH) (Check all that apply):**

- None                       Asthma                       Coronary Artery Disease                       Diabetes mellitus  
 Eczema                       Hypertension                       Peripheral Vascular Disease  
 Other (Specify PMH: \_\_\_\_\_)

**Allergies:**       Yes               No               Unknown

**If 'Yes' to allergies, specify allergies:** \_\_\_\_\_

**Habits (in past thirty days):**

**Tobacco**       Yes               No               Unknown

**Alcohol**       Yes               No               Unknown

**If 'Yes' Alcohol, alcohol heavy use (Definition: Male > 2 drinks/day, Female > 1 drink/day):**

Yes               No               Unknown

**If 'Yes' Alcohol, evidence of ethanol use 4 hours prior to snake bite:**

Yes               No               Unknown

**Recreational Drugs:**

- None                       Illicit Opioids                       Prescription Opioids  
 Amphetamines                       Cocaine                       THC/Marijuana  
 Other (specify illicit drug use: \_\_\_\_\_)                       Unknown

**Medications (Indicate all that apply):**

- None                       Cardiac                       Diabetic  
 Antiplatelet                       Anticoagulant                       Steroids  
 ACE inhibitor                       Angiotensin II Receptor  
 Other (Specify medication: \_\_\_\_\_)                       Unknown

**Has the patient had a previous snakebite?**       Yes               No               Unknown

**If 'Yes' previous snakebite,**

**Number of previous snakebites:** \_\_\_\_\_ or  Unknown

**Number of previous snakebites treated with antivenom:** \_\_\_\_\_ or  Unknown

**History of previous snakebite treated with antivenom –**

**What type of antivenom used?** \_\_\_\_\_ or  Unknown

---

---

**Bite Location (Indicate all that apply):**

Upper Extremity (UE)       Lower Extremity (LE)       Face/Neck                       Groin/Torso

**If Upper Extremity:**       Finger               Hand               Forearm       Upper Arm

**If Lower Extremity:**       Toe               Foot               Ankle               Lower leg               Thigh

**If LE bite, was patient wearing shoes?**       Yes               No               Unknown

**If 'Yes' shoes, specify type of footwear:** \_\_\_\_\_

**Was snake interaction intentional? (Definition: Patient saw the snake and could have avoided it if he/she decided to do so):**

Yes               No               Unknown

**What were the circumstances of exposure?** \_\_\_\_\_

**Was exposure occupational?**       Yes               No               Unknown

**If 'Yes' occupational, Specify occupation:** \_\_\_\_\_

**CLINICAL SIGNS - Initial Treatment Phase / Hospitalization** (*Check all that apply*)

Indicate whether each clinical sign occurred at any point due to envenomation:

Clinical Sign	Yes	No	Unknown
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecchymosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Erythema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emesis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypotension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tachycardia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angioedema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Necrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concern Compartment Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurotoxicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other clinical signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Enter additional detail for each of the clinical signs indicated above:

- Swelling:**     Swelling < 7 cm from bite                       Swelling > 100 cm from bite  
 Swelling 7-50 cm from bite                                       Swelling not otherwise specified (NOS)  
 Swelling 51-100 cm from bite
- Ecchymosis:**     Contiguous with the bite site     Not contiguous with bite site
- Erythema:**     Contiguous with the bite site     Not contiguous with bite site     Lymphangitic streaks
- Emesis:**     < 1 hour after time of bite and before receiving opioids  
 1-2 hours after bite and **before** opioids  
 < 2 hours after bite and **after** opioids  
 > 2 hours after bite and **before** opioids  
 > 2 hours after bite and **after** opioids
- Diarrhea:**     < 1 hour after time of bite                       1-2 hours after bite                       > 2 hours after bite
- Hypotension:**     Resolved with intravenous fluid resuscitation ( $\geq 20$  ml/kg IV fluids given)  
 Resolved with vasopressors  
 Unresolved (patient died)
- Angioedema:**     Prior to antivenom                       After antivenom
- Bleeding:**     Nuisance     Major     Unknown
- If Nuisance Bleeding - Type?**     Epistaxis     Gingival                       Oozing from skin puncture  
 Other (Specify nuisance bleeding: \_\_\_\_\_)
- If Major Bleeding - Type?**     GI                       Retroperitoneal     Intracranial  
 Other (Specify major bleeding: \_\_\_\_\_)
- Relative Time of Bleeding?**     Bleeding at presentation  
 Onset after presentation but prior to initial control  
 Onset after control but prior to hospital discharge
- Necrosis:**     Hemorrhagic bullae     Necrotic tissue underlying bullae     Myonecrosis

**Neurotoxicity (Indicate status of each sign):**

Clinical Sign	Yes	No	Unknown
Subjective paresthesias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fasciculations or myokymia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Objective weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory failure due to progressive weakness and paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory failure due to severe fasciculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altered mental state	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If 'Yes' neurotoxicity, did neurotoxic effects resolve in response to antivenom?**

- Yes     No     Unknown     Not applicable (No antivenom treatment)

**Specify Other Clinical Signs:** \_\_\_\_\_

**DIAGNOSTICS - Initial Treatment Phase / Hospitalization (Antivenom form)**

**Time from Bite-to-Presentation to Healthcare Facility (Any Initial Facility)** \_\_\_\_\_ Hours

**Did the patient re-present to a health care facility after discharge from another facility with a diagnosis of dry bite or mild envenomation? [If Case Direct Hospital Transfer = 'No']**

- Yes     No

**If 'Yes' to re-presented after discharge, How long was patient initially observed prior to discharge at initial healthcare facility (best estimate in hours)?** \_\_\_\_\_ Hours

**Was patient transferred from an outside hospital (OSH) to your hospital?**     Yes     No

**Did patient receive antivenom during any hospitalization? -**     **YES - Antivenom form (+AV)**

**Was the first dose of antivenom given at an OSH?**     Yes     No     Unknown

**Was any antivenom given pre-hospital by EMS or other trained field staff?**     Yes     No     Unknown

*If patient received antivenom from EMS field staff AND/OR at an outside hospital prior to treatment or transfer to your facility, then make sure to enter such dosing event(s) under the 'Initial Treatment Phase' below.*

**Is the patient in a snakebite treatment clinical trial?**

- Yes     No     Unknown

If yes, which clinical trial are they enrolled in?

Varespladib vs Placebo (Sponsor: Ophirex, Clinical Trials# NCT04996264)

Other (Specify: \_\_\_\_\_)

**Time from Bite-to-EARLIEST Available Laboratory Data to be Reported Below** \_\_\_\_\_ Hours

**Hemoglobin:**     Done, Available     Done, Not Available     Not done     Unknown

If Available, Hemoglobin – Initial / Earliest (g/dL) \_\_\_\_\_ or  Unknown

**Hematocrit:**     Done, Available     Done, Not Available     Not done     Unknown

If Available, Hematocrit - Initial / Earliest (%) \_\_\_\_\_ or  Unknown

**Platelet Count:**  Done, Available     Done, Not Available     Not done     Unknown

If Available, Platelet Count - Initial / Earliest (K/mm<sup>3</sup>) \_\_\_\_\_ or  Unknown

**Fibrinogen:**     Done, Available     Done, Not Available     Not done     Unknown

If Available, Fibrinogen - Initial / Earliest (mg/dL) \_\_\_\_\_ or  Unknown

**Prothrombin:**     Done, Available     Done, Not Available     Not done     Unknown

If Available, Prothrombin - Initial / Earliest (sec) \_\_\_\_\_ or  Unknown

**Creatine phosphokinase (CPK):**     Done, Available     Done, Not Available     Not done     Unknown

If Available, CPK Peak (IU/L) \_\_\_\_\_ or  Unknown

**Other noted lab information:** \_\_\_\_\_



---

**Treatment – Earliest Available Initial Hospital (incl ED) - Antivenom Treatment Detail**

**Type of Antivenom Treatment Obtained During Initial Hospitalization - Summary**

- CroFab       Fab2 Antivenom/Anavip       Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)

**If both CroFab and Anavip given anytime during initial hospitalization,**

**Why was the type of antivenom changed during treatment?**

- Different AV used at the outside hospital (transferred, but OSH carried different AV)  
 Patient was not responding to initial AV choice (nonresponse)  
 Allergic reaction to initial AV choice  
 Supply of initial AV ran out  
 Other reason for AV change (Specify: \_\_\_\_\_)  
 Unknown reason for change

**Prophylactic treatment for adverse reaction used?**     Yes       No       Unknown

**If ‘Yes’ prophylactic treatment used, which type of prophylactic treatment used (Check all that apply):**

- Epinephrine       Steroids       Antihistamine

---

**If patient +AV, each dosing event should be entered individually in sequential order (AV+1, AV+2, AV+3, etc). Each event includes fields related to timing of dose, reason for dose, # vials.**

---

**If patient +AV, and received multiple labs between sequential dosing events, then complete pre-AV and post-AV lab values using the labs closest to administration of each AV event (immediately preceding) and after administration of AV event (immediately following).**

---

**For Sequential +AV Dosing Events, if patient DID NOT receive multiple labs between sequential AV doses then indicate ‘Not Done’ for pre-lab indicators for the following dose as necessary.**

**For example, AV Dose #2 pre- and post-lab values completed, but *no additional labs done prior to AV Dose# 3, then indicate ‘Not Done’ for pre-lab #3 indicators.***

---

**ANTIVENOM DOSING EVENT #1**

- Enter *Pre-AV Lab Values* unless SAME as Earliest Labs (Use checkoff & *SKIP* to Post-AV Lab Values)
- Enter # Vials – Numeric Values Only (Integer including zero [0] as applicable)
- Enter *Post-AV Lab Values*
- If Final AV Dosing Event During Initial Hospital Admission, then Complete *Discharge Lab Value*. Or continue to AV+2 Dosing Event
- Enter description of any unusual circumstances regarding use of AV in free text field below “Specify Any Other Treatment”

**Dosing Event AV#1: Time from Bite-to-Antivenom in Hours** \_\_\_\_\_

**Type of Antivenom Treatment #1?**     CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 No AV this dosing event

**Dosing Event AV#1: Reason for Antivenom [Check all that apply]**

- Swelling (Specify Severity Below)
- Lab Abnormality (Specify Marker Below)
- Systematic (Specify Signs Below)
- Neurotoxicity (Specify Signs Below)
- Other reason for antivenom (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#1: Swelling Detail**

- Swelling < 7 cm from bite                       Swelling > 100 cm from bite
- Swelling 7-50 cm from bite                       Swelling NOS
- Swelling 51-100 cm from bite

**Dosing Event AV#1: Laboratory Abnormality**

- Decrease in Platelets                       Decrease in Fibrinogen                       Rising PT
- Other abnormality (Specify: \_\_\_\_\_)

**Dosing Event AV#1: Systemic Toxicity Detail**

- Shock     Hypotension     Angioedema                       Vomiting     Diarrhea
- Other systemic toxicity (Specify: \_\_\_\_\_)

**Dosing Event AV#1: Neurotoxicity**

- Fasciculation or myokymia     Objective weakness     Seizure                       Altered mental state

**Was initial control achieved with AV dose #1?** (*Definition- Initial control of envenomation is the cessation of progression of envenomation: including local effects, systemic effects, and coagulopathy.*)

- Yes                       No                       Unknown

**Adverse reaction to antivenom after AV#1?**     Yes                       No                       Unknown

**If ‘Yes’ adverse reaction to antivenom,**

**Indicate Timing of Adverse Event to Antivenom (Minutes):** \_\_\_\_\_

**Type of adverse reaction (Check all that apply):**

- Rash     Hypotension                       Angioedema     Bronchospasm
- Other Adverse Reaction (Specify: \_\_\_\_\_)

**What adverse reaction treatment provided (Check all that apply)?**

- Antivenom stopped     Corticosteroids                       Antihistamine                       Epinephrine
- Albuterol                       No treatment

**If given both CroFab and Anavip and adverse reaction occurred with AV#1,  
Which antivenom was the adverse event attributed to?**

- CroFab                       Fab2 Antivenom/Anavip                       Both CroFab and Anavip
- Other (Specify: \_\_\_\_\_)                       Unknown

**Dosing Event AV#1: Lab Values Initial Hospitalization – PRE Antivenom Dose #1: Indicate Lab Values Immediately Preceding the First Dose of Antivenom [preAV:Lab1]**

**NOTE: If No Additional Labs from those Entered as ‘Earliest’ – enter ‘Not Done’**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PreAV1: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV1: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV1: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV1: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV1: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV1: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If ‘Done, Available’ enter Values:**

PreAV1: Hemoglobin (g/dL) \_\_\_\_\_  
 PreAV1: Hematocrit (%) \_\_\_\_\_  
 PreAV1: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PreAV1: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PreAV1: Prothrombin time (sec) \_\_\_\_\_  
 PreAV1: CPK (IU/L) \_\_\_\_\_

**Dosing Event #1: Initial number of vials (Count):** \_\_\_\_\_

**Dosing Event AV#1: Lab Values Initial Hospitalization – POST Antivenom Dose #1: Indicate Lab Values Immediately After/Following the Dose of Antivenom [postAV:Lab1]**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PostAV1: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV1: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV1: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV1: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV1: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV1: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If ‘Done, Available’ enter Values:**

PostAV1: Hemoglobin (g/dL) \_\_\_\_\_  
 PostAV1: Hematocrit (%) \_\_\_\_\_  
 PostAV1: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PostAV1: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PostAV1: Prothrombin time (sec) \_\_\_\_\_  
 PostAV1: CPK (IU/L) \_\_\_\_\_

**Dosing Event AV+1: Did the patient receive another dose of antivenom during this hospitalization?**

- Yes *CONTINUE* to Antivenom Dosing Event #2  
 No *SKIP* To Section ‘Discharge Lab Values for Patients Receiving Antivenom’

**ANTIVENOM DOSING EVENT #2**

---- Enter *Pre-AV & Post-AV Lab Values*

---- Enter # *Vials* - Numeric Values Only (Integer including zero [0] as applicable)

---- Enter description of any unusual circumstances regarding use of AV in free text field below "Specify Any Other Treatment"

**Dosing Event AV#2: Time from Bite-to-Antivenom in Hours** \_\_\_\_\_

- Type of Antivenom Treatment #2?**     CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 No AV this dosing event

**Dosing Event AV#2: Reason for Antivenom [Check all that apply]**

- Swelling (Specify Severity Below)
- Lab Abnormality (Specify Marker Below)
- Systematic (Specify Signs Below)
- Neurotoxicity (Specify Signs Below)
- Other reason for antivenom (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#2: Swelling Detail**

- Swelling < 7 cm from bite                       Swelling > 100 cm from bite
- Swelling 7-50 cm from bite                       Swelling NOS
- Swelling 51-100 cm from bite

**Dosing Event AV#2: Laboratory Abnormality**

- Decrease in Platelets                       Decrease in Fibrinogen                       Rising PT
- Other abnormality (Specify: \_\_\_\_\_)

**Dosing Event AV#2: Systemic Toxicity Detail**

- Shock     Hypotension     Angioedema     Vomiting     Diarrhea
- Other systemic toxicity (Specify: \_\_\_\_\_)

**Dosing Event AV#2: Neurotoxicity**

- Fasciculation or myokymia     Objective weakness     Seizure     Altered mental state

**Was initial control achieved with AV dose #2?** (*Definition- Initial control of envenomation is the cessation of progression of envenomation: including local effects, systemic effects, and coagulopathy.*)

- Yes                       No                       Unknown

**Adverse reaction to antivenom after AV#2?**     Yes                       No                       Unknown

**If 'Yes' adverse reaction to antivenom,**

**Indicate Timing of Adverse Event to Antivenom (Minutes):** \_\_\_\_\_

**Type of adverse reaction (Check all that apply):**

- Rash     Hypotension                       Angioedema     Bronchospasm
- Other Adverse Reaction (Specify: \_\_\_\_\_)

**What adverse reaction treatment provided (Check all that apply)?**

- Antivenom stopped     Corticosteroids                       Antihistamine                       Epinephrine
- Albuterol                       No treatment

**If given both CroFab and Anavip & Adverse Reaction occurred with AV#2,**

**Which antivenom was the adverse event attributed to?**

- CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip
- Other (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#2: Lab Values Initial Hospitalization – PRE Antivenom Dose #2: Indicate Lab Values Immediately Preceding the Second Dose of Antivenom [preAV:Lab2]**

**NOTE: If No Additional Labs from those Entered Under PostAV Lab1 - Enter 'Not Done'**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PreAV2: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV2: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV2: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV2: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV2: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV2: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If 'Done, Available' enter Values:**

PreAV2: Hemoglobin (g/dL) \_\_\_\_\_  
 PreAV2: Hematocrit (%) \_\_\_\_\_  
 PreAV2: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PreAV2: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PreAV2: Prothrombin time (sec) \_\_\_\_\_  
 PreAV2: CPK (IU/L) \_\_\_\_\_

**Dosing Event #2: Additional number of vials (Count):** \_\_\_\_\_

**Dosing Event AV#2: Lab Values Initial Hospitalization – POST Antivenom Dose #2: Indicate Lab Values Immediately After/Following the Second Dose of Antivenom [postAV:Lab2]**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PostAV2: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV2: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV2: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV2: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV2: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV2: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If 'Done, Available' enter Values:**

PostAV2: Hemoglobin (g/dL) \_\_\_\_\_  
 PostAV2: Hematocrit (%) \_\_\_\_\_  
 PostAV2: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PostAV2: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PostAV2: Prothrombin time (sec) \_\_\_\_\_  
 PostAV2: CPK (IU/L) \_\_\_\_\_

**Dosing Event AV+2: Did the patient receive another dose of antivenom during this hospitalization?**

- Yes *CONTINUE* to Antivenom Dosing Event #3
- No *SKIP* To Section 'Discharge Lab Values for Patients Receiving Antivenom'

**ANTIVENOM DOSING EVENT #3**

---- Enter *Pre-AV & Post-AV Lab Values*

---- Enter # *Vials* - Numeric Values Only (Integer including zero [0] as applicable)

---- Enter description of any unusual circumstances regarding use of AV in free text field below "Specify Any Other Treatment"

**Dosing Event AV#3: Time from Bite-to-Antivenom in Hours** \_\_\_\_\_

- Type of Antivenom Treatment #3?**     CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 No AV this dosing event

**Dosing Event AV#3: Reason for Antivenom [Check all that apply]**

- Swelling (Specify Severity Below)
- Lab Abnormality (Specify Marker Below)
- Systematic (Specify Signs Below)
- Neurotoxicity (Specify Signs Below)
- Other reason for antivenom (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#3: Swelling Detail**

- Swelling < 7 cm from bite                       Swelling > 100 cm from bite
- Swelling 7-50 cm from bite                       Swelling NOS
- Swelling 51-100 cm from bite

**Dosing Event AV#3: Laboratory Abnormality**

- Decrease in Platelets                       Decrease in Fibrinogen                       Rising PT
- Other abnormality (Specify: \_\_\_\_\_)

**Dosing Event AV#3: Systemic Toxicity Detail**

- Shock     Hypotension     Angioedema     Vomiting     Diarrhea
- Other systemic toxicity (Specify: \_\_\_\_\_)

**Dosing Event AV#3: Neurotoxicity**

- Fasciculation or myokymia     Objective weakness     Seizure     Altered mental state

**Was initial control achieved with AV dose #3?** (*Definition- Initial control of envenomation is the cessation of progression of envenomation: including local effects, systemic effects, and coagulopathy.*)

- Yes                       No                       Unknown

**Adverse reaction to antivenom after AV#3?**     Yes                       No                       Unknown

**If 'Yes' adverse reaction to antivenom,**

**Indicate Timing of Adverse Event to Antivenom (Minutes):** \_\_\_\_\_

**Type of adverse reaction (Check all that apply):**

- Rash     Hypotension                       Angioedema     Bronchospasm
- Other Adverse Reaction (Specify: \_\_\_\_\_)

**What adverse reaction treatment provided (Check all that apply)?**

- Antivenom stopped     Corticosteroids                       Antihistamine                       Epinephrine
- Albuterol                       No treatment

**If given both CroFab and Anavip & Adverse Reaction occurred with AV#3,**

**Which antivenom was the adverse event attributed to?**

- CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip
- Other (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#3: Lab Values Initial Hospitalization – PRE Antivenom Dose #3: Indicate Lab Values Immediately Preceding the Third Dose of Antivenom [preAV:Lab3]**

**NOTE: If No Additional Labs from those Entered Under PostAV Lab2 - Enter 'Not Done'**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PreAV3: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV3: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV3: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV3: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV3: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV3: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'Done, Available' enter Values:

PreAV3: Hemoglobin (g/dL) \_\_\_\_\_  
 PreAV3: Hematocrit (%) \_\_\_\_\_  
 PreAV3: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PreAV3: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PreAV3: Prothrombin time (sec) \_\_\_\_\_  
 PreAV3: CPK (IU/L) \_\_\_\_\_

Dosing Event #3: Additional number of vials (Count): \_\_\_\_\_

**Dosing Event AV#3: Lab Values Initial Hospitalization – POST Antivenom Dose #3: Indicate Lab Values Immediately After/Following the Third Dose of Antivenom [postAV:Lab3]**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PostAV3: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV3: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV3: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV3: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV3: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV3: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'Done, Available' enter Values:

PostAV3: Hemoglobin (g/dL) \_\_\_\_\_  
 PostAV3: Hematocrit (%) \_\_\_\_\_  
 PostAV3: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PostAV3: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PostAV3: Prothrombin time (sec) \_\_\_\_\_  
 PostAV3: CPK (IU/L) \_\_\_\_\_

**Dosing Event AV+3: Did the patient receive another dose of antivenom during this hospitalization?**

- Yes *CONTINUE* to Antivenom Dosing Event #4  
 No *SKIP* To Section 'Discharge Lab Values for Patients Receiving Antivenom'

**ANTIVENOM DOSING EVENT #4**

---- Enter *Pre-AV & Post-AV Lab Values*

---- Enter # Vials - Numeric Values Only (Integer including zero [0] as applicable)

---- Enter description of any unusual circumstances regarding use of AV in free text field below "Specify Any Other Treatment"

**Dosing Event AV#4: Time from Bite-to-Antivenom in Hours** \_\_\_\_\_

**Type of Antivenom Treatment #4?**     CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 No AV this dosing event

**Dosing Event AV#4: Reason for Antivenom [Check all that apply]**

- Swelling (Specify Severity Below)
- Lab Abnormality (Specify Marker Below)
- Systemic (Specify Signs Below)
- Neurotoxicity (Specify Signs Below)
- Other reason for antivenom (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#4: Swelling Detail**

- Swelling < 7 cm from bite                       Swelling > 100 cm from bite
- Swelling 7-50 cm from bite                       Swelling NOS
- Swelling 51-100 cm from bite

**Dosing Event AV#4: Laboratory Abnormality**

- Decrease in Platelets                       Decrease in Fibrinogen                       Rising PT
- Other abnormality (Specify: \_\_\_\_\_)

**Dosing Event AV#4: Systemic Toxicity Detail**

- Shock     Hypotension     Angioedema     Vomiting     Diarrhea
- Other systemic toxicity (Specify: \_\_\_\_\_)

**Dosing Event AV#4: Neurotoxicity**

- Fasciculation or myokymia     Objective weakness     Seizure     Altered mental state

**Was initial control achieved with AV dose #4?** (*Definition- Initial control of envenomation is the cessation of progression of envenomation: including local effects, systemic effects, and coagulopathy.*)

- Yes                       No                       Unknown

**Adverse reaction to antivenom after AV#4?**     Yes                       No                       Unknown

**If 'Yes' adverse reaction to antivenom,**

**Indicate Timing of Adverse Event to Antivenom (Minutes):** \_\_\_\_\_

**Type of adverse reaction (Check all that apply):**

- Rash     Hypotension                       Angioedema     Bronchospasm
- Other Adverse Reaction (Specify: \_\_\_\_\_)

**What adverse reaction treatment provided (Check all that apply)?**

- Antivenom stopped     Corticosteroids                       Antihistamine                       Epinephrine
- Albuterol                       No treatment

**If given both CroFab and Anavip & Adverse Reaction occurred with AV#4,**

**Which antivenom was the adverse event attributed to?**

- CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip
- Other (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#4: Lab Values Initial Hospitalization – PRE Antivenom Dose #4: Indicate Lab Values Immediately Preceding the Fourth Dose of Antivenom [preAV:Lab4]**

**NOTE: If No Additional Labs from those Entered Under PostAV Lab3 - Enter 'Not Done'**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PreAV4: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV4: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV4: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV4: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV4: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV4: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'Done, Available' enter Values:

PreAV4: Hemoglobin (g/dL) \_\_\_\_\_  
 PreAV4: Hematocrit (%) \_\_\_\_\_  
 PreAV4: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PreAV4: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PreAV4: Prothrombin time (sec) \_\_\_\_\_  
 PreAV4: CPK (IU/L) \_\_\_\_\_

Dosing Event #4: Additional number of vials (Count): \_\_\_\_\_

**Dosing Event AV#4: Lab Values Initial Hospitalization – POST Antivenom Dose #4: Indicate Lab Values Immediately After/Following the Fourth Dose of Antivenom [postAV:Lab4]**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PostAV4: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV4: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV4: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV4: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV4: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV4: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'Done, Available' enter Values:

PostAV4: Hemoglobin (g/dL) \_\_\_\_\_  
 PostAV4: Hematocrit (%) \_\_\_\_\_  
 PostAV4: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PostAV4: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PostAV4: Prothrombin time (sec) \_\_\_\_\_  
 PostAV4: CPK (IU/L) \_\_\_\_\_

**Dosing Event AV+4: Did the patient receive another dose of antivenom during this hospitalization?**

- Yes *CONTINUE* to Antivenom Dosing Event #5  
 No *SKIP* To Section 'Discharge Lab Values for Patients Receiving Antivenom'

**ANTIVENOM DOSING EVENT #5**

---- Enter Pre-AV & Post-AV Lab Values

---- Enter # Vials - Numeric Values Only (Integer including zero [0] as applicable)

---- Enter description of any unusual circumstances regarding use of AV in free text field below "Specify Any Other Treatment"

**Dosing Event AV#5: Time from Bite-to-Antivenom in Hours** \_\_\_\_\_

**Type of Antivenom Treatment #5?**     CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 No AV this dosing event

**Dosing Event AV#5: Reason for Antivenom [Check all that apply]**

- Swelling (Specify Severity Below)
- Lab Abnormality (Specify Marker Below)
- Systemic (Specify Signs Below)
- Neurotoxicity (Specify Signs Below)
- Other reason for antivenom (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#5: Swelling Detail**

- Swelling < 7 cm from bite                       Swelling > 100 cm from bite
- Swelling 7-50 cm from bite                       Swelling NOS
- Swelling 51-100 cm from bite

**Dosing Event AV#5: Laboratory Abnormality**

- Decrease in Platelets                       Decrease in Fibrinogen                       Rising PT
- Other abnormality (Specify: \_\_\_\_\_)

**Dosing Event AV#5: Systemic Toxicity Detail**

- Shock     Hypotension     Angioedema     Vomiting     Diarrhea
- Other systemic toxicity (Specify: \_\_\_\_\_)

**Dosing Event AV#5: Neurotoxicity**

- Fasciculation or myokymia     Objective weakness     Seizure     Altered mental state

**Was initial control achieved with AV dose #5?** (*Definition- Initial control of envenomation is the cessation of progression of envenomation: including local effects, systemic effects, and coagulopathy.*)

- Yes                       No                       Unknown

**Adverse reaction to antivenom after AV#5?**     Yes                       No                       Unknown

**If 'Yes' adverse reaction to antivenom,**

**Indicate Timing of Adverse Event to Antivenom (Minutes):** \_\_\_\_\_

**Type of adverse reaction (Check all that apply):**

- Rash     Hypotension                       Angioedema     Bronchospasm
- Other Adverse Reaction (Specify: \_\_\_\_\_)

**What adverse reaction treatment provided (Check all that apply)?**

- Antivenom stopped     Corticosteroids                       Antihistamine                       Epinephrine
- Albuterol                       No treatment

**If given both CroFab and Anavip & Adverse Reaction occurred with AV#5,**

**Which antivenom was the adverse event attributed to?**

- CroFab     Fab2 Antivenom/Anavip     Both CroFab and Anavip
- Other (Specify: \_\_\_\_\_)
- Unknown

**Dosing Event AV#5: Lab Values Initial Hospitalization – PRE Antivenom Dose #5: Indicate Lab Values Immediately Preceding the Fifth Dose of Antivenom [preAV:Lab5]**

**NOTE: If No Additional Labs from those Entered Under PostAV Lab4 - Enter 'Not Done'**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PreAV5: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV5: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV5: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV5: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV5: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PreAV5: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'Done, Available' enter Values:

PreAV5: Hemoglobin (g/dL) \_\_\_\_\_  
 PreAV5: Hematocrit (%) \_\_\_\_\_  
 PreAV5: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PreAV5: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PreAV5: Prothrombin time (sec) \_\_\_\_\_  
 PreAV5: CPK (IU/L) \_\_\_\_\_

Dosing Event #5: Additional number of vials (Count): \_\_\_\_\_

**Dosing Event AV#5: Lab Values Initial Hospitalization – POST Antivenom Dose #5: Indicate Lab Values Immediately After/Following the Fifth Dose of Antivenom [postAV:Lab5]**

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
PostAV5: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV5: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV5: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV5: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV5: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PostAV5: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'Done, Available' enter Values:

PostAV5: Hemoglobin (g/dL) \_\_\_\_\_  
 PostAV5: Hematocrit (%) \_\_\_\_\_  
 PostAV5: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
 PostAV5: Fibrinogen level (mg/dL) \_\_\_\_\_  
 PostAV5: Prothrombin time (sec) \_\_\_\_\_  
 PostAV5: CPK (IU/L) \_\_\_\_\_

**Dosing Event AV+5: Did the patient receive another dose of antivenom during this hospitalization?**

- Yes *CONTINUE* to Antivenom Dosing Event #6  
 No *SKIP* To Section 'Discharge Lab Values for Patients Receiving Antivenom'

***For Additional Dosing Events – Use AV Supplemental Forms (AV#6-10).***

---

## Discharge Lab Values for Patients Receiving Antivenom

If no other antivenom dosing events to report, then please complete the final laboratory discharge section:

Final Hospital Discharge: Indicate Final Laboratory Values Status [AV+]:

- AV+ - Labs already entered as final post-AV dose [*SKIP to Treatment Procedures*]
- AV+ - Additional final lab preceding discharge available [*CONTINUE to Discharge Labs*]

### Discharge Lab Values Initial Hospitalization - AV+ Cases

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
Discharge: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge: CPK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If 'Done, Available' enter Values:

Final Discharge +AV: Hemoglobin (g/dL) \_\_\_\_\_

Final Discharge +AV: Hematocrit (%) \_\_\_\_\_

Final Discharge +AV: Platelets (K/mm<sup>5</sup>) \_\_\_\_\_

Final Discharge +AV: Fibrinogen level (mg/dL) \_\_\_\_\_

Final Discharge +AV: Prothrombin time (sec) \_\_\_\_\_

Final Discharge +AV: CPK (IU/L) \_\_\_\_\_

---

## Treatment – Initial Treatment Procedure During Initial Hospitalization: Summary

Procedures:  Yes  No  Unknown

Procedure(s) Surgery: Time-since-Bite (Hours) \_\_\_\_\_

\*If second procedure conducted at different time during initial hospitalization – enter info in 'Other Treatment'

Procedure(s) Performed: [*Check all that apply*]  Debridement bullae  
 Dermotomy  
 Fasciotomy  
 Incision and drainage of wound  
 Incision and drainage of abscess  
 Other (Specify procedure: \_\_\_\_\_)

Procedure location? [*Check all that apply*]  Digit  
 Upper Extremity  
 Lower Extremity  
 Other (Specify location: \_\_\_\_\_)

Specify any Other Treatment: \_\_\_\_\_

---

## Summary Length of Stay (LOS) – Initial Hospitalization

Total time in hospital:  <24 hours  25-48 hours  49-72 hours  
 Other (Specify other total time in Hospital (Days): \_\_\_\_\_)

Total time in ICU:  Never  
 <24 hours  25-48 hours  49-72 hours  
 Other (Specify other total time in ICU (Days): \_\_\_\_\_)

---

---

**PATIENT FOLLOW UP INFORMATION (After Initial Hospital Discharge)**

Is follow up information available for this patient?  Yes  No  Pending

If 'Yes' - Proceed to enter detailed information for F/U visits #1-#3  
If >3 F/U visits available, use additional summary field provided.  
**PROCEED** to 'Final Outcome' section

If 'No' - Indicate lost to follow up and any detail.  
**PROCEED** to 'Final Outcome' section

If 'Pending' - Submit partial case, save, request unique html survey link, retain link for electronic record re-entry.

**Explain why case considered lost to follow up [Check all that apply]:**

- Multiple attempts to contact failed
  - Patient refused or no show
  - Patient seen at another medical location (data unavailable)
  - Patient seen by other medical specialty (data unavailable)
  - Patient followed by PCP (data not made available)
  - Patient relocated (data unavailable)
  - Patient incarcerated
  - Patient died during initial hospitalization
- 

**FOLLOW UP #1 DETAIL**

Method of follow up #1:  Direct patient evaluation  
 Spoke with patient on telephone  
 Other (Specify other method of follow up #1: \_\_\_\_\_)

Days since last Antivenom at F/U #1: \_\_\_\_\_

Total Hours since Bite F/U #1:  <48 Hours  ≥48 Hours

Any Laboratory Values Available at Follow Up #1:  Yes  No

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
FU Lab1: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab1: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab1: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab1: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab1: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab1: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If 'Done, Available' enter Values:**

FU Lab1: Hemoglobin (g/dL) \_\_\_\_\_  
FU Lab1: Hematocrit (%) \_\_\_\_\_  
FU Lab1: Platelets (K/mm<sup>3</sup>) \_\_\_\_\_  
FU Lab1: Fibrinogen level (mg/dL) \_\_\_\_\_  
FU Lab1: Prothrombin time (sec) \_\_\_\_\_

Follow Up #1 Status of Swelling:  Not present  Improved  Stable  Extending  Unknown  
Follow Up #1 Status of Necrosis:  Not present  Improved  Stable  Extending  Unknown  
Follow Up #1 Status of Pain:  Not present  Improved  Stable  Extending  Unknown

- Follow Up #1: Patient Treated with Opioid**     Yes – Continued from Initial Hospitalization  
 Yes – Initiated Follow Up #1  
 No  
 Unknown

**Follow Up #1 Status Late Bleeding Occurrence:**     Occurred     Did not occur     Did not assess for late bleeding

**Specify Type of Late (Follow Up) Bleeding:**     Nuisance     Major  
 Bleeding in extremity with >3 g/dL Hgb drop

**Specify Type of Late Follow Up Nuisance Bleeding:**     Epistaxis     Gingival     Oozing from punctures  
 Other (Specify nuisance bleeding: \_\_\_\_\_)

**Specify Type of Late Follow Up Major Bleeding:**     GI     Retroperitoneal     Intracranial  
 Other (Specify major bleeding: \_\_\_\_\_)

**Patient treated for Late Bleeding Follow Up #1? [Check all that apply]**

- No treatment  
 Antivenom (Enter Detail Under Readmission)  
 Blood products (Specify below)  
 Other (Specify late bleed treatment : \_\_\_\_\_)

**Follow Up #1 Blood Products: Indicate Type of Reagent**

- PRBCs        - Number of units (Count): \_\_\_\_\_  
 Platelets      - Number of units (Count): \_\_\_\_\_  
 FFP            - Number of units (Count): \_\_\_\_\_  
 Cryoprecipitate - Number of units (Count): \_\_\_\_\_  
 rFVIIa        - Number of units (Count): \_\_\_\_\_  
 Other blood products: (Specify: \_\_\_\_\_)

**Follow Up #1 Serum Sickness Symptoms [Check all that apply]:**

- Not Applicable (**No AV Treatment**)  
 None [+AV Tx]     Rash         Wheezing     Myalgias     Fever  
 Other (Specify serum sickness symptoms follow up #1: \_\_\_\_\_)

**Serum Sickness Treatment Follow Up #1:**

- No Treatment                       Steroids     Antihistamines  
 Other (Specify treatments follow up #1: \_\_\_\_\_)

**Patient Readmitted Follow Up #1?**     Yes     No    *If 'No', SKIP to Q: Final Outcome Indicator*

**At this Follow Up #1 - Why Patient Readmitted [Check all that apply]:**

Readmission Reason Follow Up #1	Yes	No	Unknown
Late thrombocytopenia (platelets <120 K/mm <sup>3</sup> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Late hypofibrinogenemia (fibrinogen <170 mg/dL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Late coagulopathy (prothrombin time >15 sec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wound Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify Other Reason Readmission Follow Up #1: \_\_\_\_\_

**Follow Up #1: Treatment during this F/U #1 Readmission (Not Previously Entered for Late Bleeding or Serum Sickness):**

- Yes       No      *If 'No', SKIP to Q: Final Outcome Indicator*

**If "Yes" Treatment Readmission F/U #1 – Indicate Additional Treatment Received during Readmission**

- Antivenom  
 Procedure  
 Other Pharmaceutical Treatment  
 Other Non-Pharmaceutical Treatment  
 Unknown

**FU #1 Readmission Antivenom Treatment – Indicate Reason**

- Swelling (Specify Severity Below)  
 Lab Abnormality (Specify Marker Below)  
 Systematic (Specify Signs Below)  
 Neurotoxicity (Specify Signs Below)  
 Maintenance  
 Other Reason (Specify: \_\_\_\_\_)  
 Unknown

**F/U #1 Readmission: Swelling Detail**

- Swelling < 7 cm from bite       Swelling > 100 cm from bite  
 Swelling 7-50 cm from bite       Swelling NOS  
 Swelling 51-100 cm from bite

**F/U #1 Readmission: Laboratory Abnormality**

- Decrease in Platelets       Decrease in Fibrinogen       Rising PT  
 Other abnormality (Specify: \_\_\_\_\_)

**F/U #1 Readmission: Systemic Toxicity Detail**

- Shock       Hypotension       Angioedema       Vomiting       Diarrhea  
 Other systemic toxicity (Specify: \_\_\_\_\_)

**F/U #1 Readmission: Neurotoxicity**

- Fasciculation or myokymia       Objective weakness  
 Seizure       Altered mental state

**If Antivenom Treatment Readmission F/U #1 – Enter Vial Count**

FU #1: Initial Number of Vials \_\_\_\_\_  
FU #1: Additional Vials \_\_\_\_\_  
FU #1: Total Number of Vials \_\_\_\_\_

**If Antivenom Treatment Readmission F/U #1 – Indicate Type of Antivenom Treatment**

- CroFab       Fab2 Antivenom/Anavip       Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 Unknown

**If both CroFab and Anavip given, why was the type of antivenom changed during treatment?**

- Different AV used at the outside hospital (transferred, but OSH carried different AV)  
 Patient was not responding to initial AV choice (nonresponse)  
 Allergic reaction to initial AV choice  
 Supply of initial AV ran out  
 Other reason for AV change (Specify: \_\_\_\_\_)  
 Unknown reason for change

**F/U #1 Readmission: Procedure(s) Performed** [Check all that apply]

- Debridement bullae
- Dermotomy
- Fasciotomy
- Incision and drainage of wound
- Incision and drainage of abscess
- Other (Specify procedure type: \_\_\_\_\_)

**F/U #1 Readmission: Procedure(s) Location** [Check all that apply]

- Digit
- Upper Extremity
- Lower Extremity
- Other (Specify location: \_\_\_\_\_)

**F/U #1 Readmission: Procedure(s) Surgery: Time-since-Bite (Hours)** \_\_\_\_\_

**F/U #1 Readmission: Specify Pharmaceutical Treatment Detail:** \_\_\_\_\_

**F/U #1 Readmission: Specify Non-Pharmaceutical Treatment Detail:** \_\_\_\_\_

**Is this the final follow up? (Follow Up #1):**  Yes  No *If 'Yes', SKIP to Final Outcome*

**Method of follow up #2:**  Direct patient evaluation  
 Spoke with patient on telephone  
 Other (Specify other method of follow up #2: \_\_\_\_\_)

**Days since last Antivenom at F/U #2:** \_\_\_\_\_

**Total Hours since Bite F/U #2:**  <48 Hours  ≥48 Hours

**Any Laboratory Values Available at Follow Up #2:**  Yes  No

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
FU Lab2: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab2: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab2: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab2: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab2: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab2: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If 'Done, Available' enter Values:**

**FU Lab2: Hemoglobin (g/dL)** \_\_\_\_\_  
**FU Lab2: Hematocrit (%)** \_\_\_\_\_  
**FU Lab2: Platelets (K/mm<sup>3</sup>)** \_\_\_\_\_  
**FU Lab2: Fibrinogen level (mg/dL)** \_\_\_\_\_  
**FU Lab2: Prothrombin time (sec)** \_\_\_\_\_

**Follow Up #2 Status of Swelling:**  Not present  Improved  Stable  Extending  Unknown

**Follow Up #2 Status of Necrosis:**  Not present  Improved  Stable  Extending  Unknown

**Follow Up #2 Status of Pain:**  Not present  Improved  Stable  Extending  Unknown

- Follow Up #2: Patient Treated with Opioid**     Yes – Continued from Initial Hospitalization  
 Yes – Initiated Follow Up #2  
 No  
 Unknown

**Follow Up #2 Status Late Bleeding Occurrence:**     Occurred     Did not occur     Did not assess for late bleeding

**Specify Type of Late (Follow Up) Bleeding:**     Nuisance     Major  
 Bleeding in extremity with >3 g/dL Hgb drop

**Specify Type of Late Follow Up Nuisance Bleeding:**     Epistaxis     Gingival     Oozing from punctures  
 Other (Specify nuisance bleeding: \_\_\_\_\_)

**Specify Type of Late Follow Up Major Bleeding:**     GI     Retroperitoneal     Intracranial  
 Other (Specify major bleeding: \_\_\_\_\_)

**Patient treated for Late Bleeding Follow Up #2? [Check all that apply]**

- No treatment  
 Antivenom (Enter Detail Under Readmission)  
 Blood products (Specify below)  
 Other (Specify late bleed treatment : \_\_\_\_\_)

**Follow Up #2 Blood Products: Indicate Type of Reagent**

- PRBCs        - Number of units (Count): \_\_\_\_\_  
 Platelets     - Number of units (Count): \_\_\_\_\_  
 FFP            - Number of units (Count): \_\_\_\_\_  
 Cryoprecipitate - Number of units (Count): \_\_\_\_\_  
 rFVIIa        - Number of units (Count): \_\_\_\_\_  
 Other blood products: (Specify: \_\_\_\_\_)

**Follow Up #2 Serum Sickness Symptoms [Check all that apply]:**

- Not Applicable (**No AV Treatment**)  
 None [+AV Tx]     Rash         Wheezing     Myalgias     Fever  
 Other (Specify serum sickness symptoms follow up #2: \_\_\_\_\_)

**Serum Sickness Treatment Follow Up #2:**

- No Treatment                       Steroids     Antihistamines  
 Other (Specify treatments follow up #2: \_\_\_\_\_)

**Patient Readmitted Follow Up #2?**     Yes     No    *If 'No', SKIP to Q: Final Outcome Indicator*

**At this Follow Up #2 - Why Patient Readmitted [Check all that apply]:**

Readmission Reason Follow Up #2	Yes	No	Unknown
Late thrombocytopenia (platelets <120 K/mm <sup>3</sup> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Late hypofibrinogenemia (fibrinogen <170 mg/dL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Late coagulopathy (prothrombin time >15 sec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wound Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify Other Reason Readmission Follow Up #2: \_\_\_\_\_

**Follow Up #2: Treatment during this F/U #2 Readmission (Not Previously Entered for Late Bleeding or Serum Sickness):**

- Yes       No      *If 'No', SKIP to Q: Final Outcome Indicator*

**If "Yes" Treatment Readmission F/U #2 – Indicate Additional Treatment Received during Readmission**

- Antivenom  
 Procedure  
 Other Pharmaceutical Treatment  
 Other Non-Pharmaceutical Treatment  
 Unknown

**FU #2 Readmission Antivenom Treatment – Indicate Reason**

- Swelling (Specify Severity Below)  
 Lab Abnormality (Specify Marker Below)  
 Systematic (Specify Signs Below)  
 Neurotoxicity (Specify Signs Below)  
 Maintenance  
 Other Reason (Specify: \_\_\_\_\_)  
 Unknown

**F/U #2 Readmission: Swelling Detail**

- Swelling < 7 cm from bite       Swelling > 100 cm from bite  
 Swelling 7-50 cm from bite       Swelling NOS  
 Swelling 51-100 cm from bite

**F/U #2 Readmission: Laboratory Abnormality**

- Decrease in Platelets       Decrease in Fibrinogen       Rising PT  
 Other abnormality (Specify: \_\_\_\_\_)

**F/U #2 Readmission: Systemic Toxicity Detail**

- Shock       Hypotension       Angioedema       Vomiting       Diarrhea  
 Other systemic toxicity (Specify: \_\_\_\_\_)

**F/U #2 Readmission: Neurotoxicity**

- Fasciculation or myokymia       Objective weakness  
 Seizure       Altered mental state

**If Antivenom Treatment Readmission F/U #2 – Enter Vial Count**

FU #2: Initial Number of Vials \_\_\_\_\_  
FU #2: Additional Vials \_\_\_\_\_  
FU #2: Total Number of Vials \_\_\_\_\_

**If Antivenom Treatment Readmission F/U #2 – Indicate Type of Antivenom Treatment**

- CroFab       Fab2 Antivenom/Anavip       Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 Unknown

**If both CroFab and Anavip given, why was the type of antivenom changed during treatment?**

- Different AV used at the outside hospital (transferred, but OSH carried different AV)  
 Patient was not responding to initial AV choice (nonresponse)  
 Allergic reaction to initial AV choice  
 Supply of initial AV ran out  
 Other reason for AV change (Specify: \_\_\_\_\_)  
 Unknown reason for change

**F/U #2 Readmission: Procedure(s) Performed** [Check all that apply]

- Debridement bullae
- Dermotomy
- Fasciotomy
- Incision and drainage of wound
- Incision and drainage of abscess
- Other (Specify procedure type: \_\_\_\_\_)

**F/U #2 Readmission: Procedure(s) Location** [Check all that apply]

- Digit
- Upper Extremity
- Lower Extremity
- Other (Specify location: \_\_\_\_\_)

**F/U #2 Readmission: Procedure(s) Surgery: Time-since-Bite (Hours)** \_\_\_\_\_

**F/U #2 Readmission: Specify Pharmaceutical Treatment Detail:** \_\_\_\_\_

**F/U #2 Readmission: Specify Non-Pharmaceutical Treatment Detail:** \_\_\_\_\_

**Is this the final follow up? (Follow Up #2):**  Yes  No *If 'Yes', SKIP to Final Outcome*

**Method of follow up #3:**  Direct patient evaluation  
 Spoke with patient on telephone  
 Other (Specify other method of follow up #3: \_\_\_\_\_)

**Days since last Antivenom at F/U #3:** \_\_\_\_\_

**Total Hours since Bite F/U #3:**  <48 Hours  ≥48 Hours

**Any Laboratory Values Available at Follow Up #3:**  Yes  No

Lab Test	Done, Available	Done, Not Available	Not Done	Unknown
FU Lab3: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab3: Hematocrit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab3: Platelets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab3: Fibrinogen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab3: Prothrombin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FU Lab3: Hemoglobin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If 'Done, Available' enter Values:**

**FU Lab3: Hemoglobin (g/dL)** \_\_\_\_\_  
**FU Lab3: Hematocrit (%)** \_\_\_\_\_  
**FU Lab3: Platelets (K/mm<sup>3</sup>)** \_\_\_\_\_  
**FU Lab3: Fibrinogen level (mg/dL)** \_\_\_\_\_  
**FU Lab3: Prothrombin time (sec)** \_\_\_\_\_

**Follow Up #3 Status of Swelling:**  Not present  Improved  Stable  Extending  Unknown

**Follow Up #3 Status of Necrosis:**  Not present  Improved  Stable  Extending  Unknown

**Follow Up #3 Status of Pain:**  Not present  Improved  Stable  Extending  Unknown

- Follow Up #3: Patient Treated with Opioid**     Yes – Continued from Initial Hospitalization  
 Yes – Initiated Follow Up #3  
 No  
 Unknown

**Follow Up #3 Status Late Bleeding Occurrence:**     Occurred     Did not occur     Did not assess for late bleeding

**Specify Type of Late (Follow Up) Bleeding:**     Nuisance     Major  
 Bleeding in extremity with >3 g/dL Hgb drop

**Specify Type of Late Follow Up Nuisance Bleeding:**     Epistaxis     Gingival     Oozing from punctures  
 Other (Specify nuisance bleeding: \_\_\_\_\_)

**Specify Type of Late Follow Up Major Bleeding:**     GI     Retroperitoneal     Intracranial  
 Other (Specify major bleeding: \_\_\_\_\_)

**Patient treated for Late Bleeding Follow Up #3? [Check all that apply]**

- No treatment  
 Antivenom (Enter Detail Under Readmission)  
 Blood products (Specify below)  
 Other (Specify late bleed treatment : \_\_\_\_\_)

**Follow Up #3 Blood Products: Indicate Type of Reagent**

- PRBCs        - Number of units (Count): \_\_\_\_\_  
 Platelets     - Number of units (Count): \_\_\_\_\_  
 FFP            - Number of units (Count): \_\_\_\_\_  
 Cryoprecipitate - Number of units (Count): \_\_\_\_\_  
 rFVIIa        - Number of units (Count): \_\_\_\_\_  
 Other blood products: (Specify: \_\_\_\_\_)

**Follow Up #3 Serum Sickness Symptoms [Check all that apply]:**

- Not Applicable (**No AV Treatment**)  
 None [+AV Tx]     Rash         Wheezing     Myalgias     Fever  
 Other (Specify serum sickness symptoms follow up #3: \_\_\_\_\_)

**Serum Sickness Treatment Follow Up #3:**

- No Treatment                       Steroids     Antihistamines  
 Other (Specify treatments follow up #3: \_\_\_\_\_)

**Patient Readmitted Follow Up #3?**     Yes     No    *If 'No', SKIP to Q: Final Outcome Indicator*

**At this Follow Up #3 - Why Patient Readmitted [Check all that apply]:**

Readmission Reason Follow Up #3	Yes	No	Unknown
Late thrombocytopenia (platelets <120 K/mm <sup>3</sup> )	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Late hypofibrinogenemia (fibrinogen <170 mg/dL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Late coagulopathy (prothrombin time >15 sec)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wound Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify Other Reason Readmission Follow Up #3: \_\_\_\_\_

**Follow Up #3: Treatment during this F/U #3 Readmission (Not Previously Entered for Late Bleeding or Serum Sickness):**

- Yes       No      *If 'No', SKIP to Q: Final Outcome Indicator*

**If "Yes" Treatment Readmission F/U #3 – Indicate Additional Treatment Received during Readmission**

- Antivenom  
 Procedure  
 Other Pharmaceutical Treatment  
 Other Non-Pharmaceutical Treatment  
 Unknown

**FU #3 Readmission Antivenom Treatment – Indicate Reason**

- Swelling (Specify Severity Below)  
 Lab Abnormality (Specify Marker Below)  
 Systematic (Specify Signs Below)  
 Neurotoxicity (Specify Signs Below)  
 Maintenance  
 Other Reason (Specify: \_\_\_\_\_)  
 Unknown

**F/U #3 Readmission: Swelling Detail**

- Swelling < 7 cm from bite       Swelling > 100 cm from bite  
 Swelling 7-50 cm from bite       Swelling NOS  
 Swelling 51-100 cm from bite

**F/U #3 Readmission: Laboratory Abnormality**

- Decrease in Platelets       Decrease in Fibrinogen       Rising PT  
 Other abnormality (Specify: \_\_\_\_\_)

**F/U #3 Readmission: Systemic Toxicity Detail**

- Shock       Hypotension       Angioedema       Vomiting       Diarrhea  
 Other systemic toxicity (Specify: \_\_\_\_\_)

**F/U #3 Readmission: Neurotoxicity**

- Fasciculation or myokymia       Objective weakness  
 Seizure       Altered mental state

**If Antivenom Treatment Readmission F/U #3 – Enter Vial Count**

FU #3: Initial Number of Vials \_\_\_\_\_  
FU #3: Additional Vials \_\_\_\_\_  
FU #3: Total Number of Vials \_\_\_\_\_

**If Antivenom Treatment Readmission F/U #3 – Indicate Type of Antivenom Treatment**

- CroFab       Fab2 Antivenom/Anavip       Both CroFab and Anavip  
 Other type of antivenom (Incl RCT-related AV) (Specify: \_\_\_\_\_)  
 Unknown

**If both CroFab and Anavip given, why was the type of antivenom changed during treatment?**

- Different AV used at the outside hospital (transferred, but OSH carried different AV)  
 Patient was not responding to initial AV choice (nonresponse)  
 Allergic reaction to initial AV choice  
 Supply of initial AV ran out  
 Other reason for AV change (Specify: \_\_\_\_\_)  
 Unknown reason for change

**F/U #3 Readmission: Procedure(s) Performed** [*Check all that apply*]

- Debridement bullae
- Dermotomy
- Fasciotomy
- Incision and drainage of wound
- Incision and drainage of abscess
- Other (Specify procedure type: \_\_\_\_\_)

**F/U #3 Readmission: Procedure(s) Location** [*Check all that apply*]

- Digit
- Upper Extremity
- Lower Extremity
- Other (Specify location: \_\_\_\_\_)

**F/U #3 Readmission: Procedure(s) Surgery: Time-since-Bite (Hours)** \_\_\_\_\_

**F/U #3 Readmission: Specify Pharmaceutical Treatment Detail:** \_\_\_\_\_

**F/U #3 Readmission: Specify Non-Pharmaceutical Treatment Detail:** \_\_\_\_\_

**Is this the final follow up? (Follow Up #3):**     Yes    *If 'Yes', SKIP to Final Outcome*  
 No    *If 'No', Continue to Follow Up >#3*

---

---

**ADDITIONAL FOLLOW UP DETAIL**

**Enter count of additional follow up visits beyond follow up #3:** \_\_\_\_\_

**Follow up >#3: Enter summary lab/clinical information of interest, particularly any hematologic recurrence(s) or readmissions:**

---

---

---

---

**FINAL OUTCOME**

**Did the patient die?**     Yes             No

**Final number of days since bite:** \_\_\_\_\_  
(Definition: Equals number of days to last follow up or day of initial release if initially patient lost to follow up)

**Was this case considered a 'dry bite'?**    Yes             No

**Were any of the following conditions noted any time after the initial hospitalization? (Check all that apply)**  
[Note: Hematologic recurrence requires confirmation by laboratory measures – in contrast to ‘late bleeding’]

- Late thrombocytopenia (platelets < 120 K/mm3)
- Late coagulopathy (prothrombin time >15 sec)
- Late hypofibrinogenemia (fibrinogen < 170 mg/dL)
- None Listed

**At final follow up (or day of initial release if lost to follow up),**

**Was residual functional deficit present?**     Yes             No

- What residual functional deficit?**
- Loss of mobility in digit
  - Loss of mobility in hand or foot
  - Loss of mobility in knee or elbow

**Was permanent tissue loss present?**    Yes             No

- What permanent tissue loss?**
- Loss of tissue requiring skin graft     Amputation of digit
  - Other (Specify degree of permanent tissue loss: \_\_\_\_\_)

**Additional important or summary information related to final patient outcomes:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Any other unique or important information, if any, or brief summary of case:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please specify name(s) of the treating toxicologist(s):** \_\_\_\_\_

**Case completed?**     Yes             No