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**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, evidence of ethanol use 4 hours prior to snake bite:**

- Yes                       No                       Unknown

**Was the patient acutely intoxicated with alcohol or other substances when bitten?**

- Yes                       No                       Unknown

**If yes, choose substances the patient was acutely intoxicated with at the time of the snakebite:**

- Alcohol                       Sedative-hypnotics                       Cocaine  
 Opioids                       Hallucinogens                       THC/Marijuana  
 Amphetamines                       Other (specify illicit drug use: \_\_\_\_\_)                       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

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**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 (No antivenom treatment)                       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

Concern for Compartment Syndrome: Enter ICP (mm Hg) : \_\_\_\_\_ or  Unknown

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: \_\_\_\_\_

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**DIAGNOSTICS - Initial Treatment Phase / Hospitalization (No Antivenom) –**

**\*\* IF ANTIVENOM PROVIDED AT ANY TIME USE AV\_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? -  **NO - No Antivenom form (-AV)**

If no antivenom was given, was it based on the physician and/or patients preference? (check all that apply)

Patient decision

High cost

Safety concerns

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

Physician decision

Not clinically warranted

Risks outweigh the benefits (safety concerns)

AV not available

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

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 – Field Treatment Received Prior to Presentation at Any Hospital**

**Field Therapy Performed?**  Yes  No  Unknown

**If ‘Yes’ field therapy performed, type of field treatment performed?**

- Ice  Immobilization  Incision  
 Pressure immobilization bandage  Suction/Sawyer Device  Tourniquet  
 Other field treatment (Specify: \_\_\_\_\_)

**Treatment – Emergency Department Treatment Received at Any Hospital**

**Initial ED Treatment?**  Yes  No  Unknown

**If ‘Yes’ initial ED treatment, type of initial ED treatment performed?**

- Antibiotics  N/A Antivenom  Elevation  
 Ice  Immobilization  
 Other initial ED therapy (Specify: \_\_\_\_\_)

**Treatment – Initial Treatment Phase During Initial Hospitalization: Summary**

Treatment	Yes	No	Unknown
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antiemetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antivenom	N/A	<input type="checkbox"/>	<input type="checkbox"/>
Blood Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevation of Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous Fluid Resuscitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intubation-Mechanical Ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opioids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vasopressor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Post ED Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Antibiotic Treatment Reason:**     Prophylactic  $\geq 1$  dose  
 Empiric for erythema or suspected cellulitis  
 Treatment of confirmed infection
- Antiemetic Treatment Reason:**     Prophylactic  
 Treatment of nausea **prior to** opioid administration  
 Treatment of nausea **after** opioid administration
- Vasopressor Treatment Reason:**     Treatment of hypotension  
 Treatment of allergic reaction
- Blood Products Treatment:**         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: \_\_\_\_\_)

**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): \_\_\_\_\_)

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**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

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**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 bite 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 Status of Function:  Baseline  Improved  Unchanged  Worsening  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 Status of Function:**  Baseline  Improved  Unchanged  Worsening  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 Status of Function:**  Baseline  Improved  Unchanged  Worsening  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 7-50 cm from bite
- Swelling 51-100 cm from bite
- Swelling > 100 cm from bite
- Swelling NOS

**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*

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**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:**

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**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/mm<sup>3</sup>)
- Late coagulopathy (prothrombin time >15 sec)
- Late hypofibrinogenemia (fibrinogen < 170 mg/dL)
- Infection
- None Listed

**If infection, were antibiotics started?**

- Yes             No             Unknown

**If infection, which antibiotic was given?**

- Amoxicillin
- Amoxicillin/clavulanate (Augmentin)
- Cephalexin (Keflex)
- Cefuroxime (Ceftin)
- Clindamycin
- Doxycycline
- Trimethoprim/sulfamethoxazole (Bactrim)
- Other (Specify antibiotic: \_\_\_\_\_)

**If infection, was a wound culture performed?**

- Yes             No             Unknown

**If infection, was a procedure performed?**

- Yes             No             Unknown

**If procedure was performed either as an outpatient or inpatient, what type of procedure?**

- Incision and drainage of abscess
- Wound debridement
- Other (Specify procedure: \_\_\_\_\_)

**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):** \_\_\_\_\_

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**Case completed?**       Yes       No

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