

# Hairy Cell Leukemia

Producer \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Client \_\_\_\_\_ Age/DOB \_\_\_\_\_ Sex \_\_\_\_\_

If your client has had CAD, please answer the following

1. Please list date of the diagnosis: \_\_\_\_\_

2. Please note type of treatment (check all that apply):

Close observation only      q      Pentostatin  
Splenectomy                      Bone marrow transplant  
Interferon                          Other, please specify

2-cdA

3. Is your client on any medications?

yes, please give details \_\_\_\_\_

no

4. Please provide result of the most recent CBC (complete blood count):

date \_\_\_\_\_

hemoglobin \_\_\_\_\_

white blood cell count \_\_\_\_\_

platelet count \_\_\_\_\_

5. Has there been any evidence of recurrence?

yes, please give details \_\_\_\_\_

no

6. Has your client smoked cigarettes in the last 12 months?

yes

no

7. Does your client have any other major health problems? (ex: heart disease, etc.)

yes, please give details \_\_\_\_\_

no