

# BLEEDING CONTROL FORM - PART 1

Si prega di compilare tutti i campi (spuntare almeno un campo per ogni domanda) ed inserire un codice di sei cifre alfanumeriche nella casella Data record per identificare il form e completare successivamente il giudizio finale nella seconda parte.  
Inviare il form al Fax n. 030 3469896 o alla e-mail r.manta@ausl.mo.it, all'attenzione del Dr. Raffaele Manta

<b>Investigator (First and last name)</b>			<b>Data record</b>		
<b>Endoscopic unit of (Name and address)</b>					
<b>Telefono</b>		<b>Fax</b>		<b>email</b>	
<b>Date of compilation</b>					

<b>Intervention</b>	
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<b>1. Type of bleeding (Forrest classification)</b>	
Acute hemorrhage	Lesions without active bleeding
<input type="checkbox"/> Forrest 1A (Arterial, spurting hemorrhage)	<input type="checkbox"/> Forrest III (No signs of recent hemorrhage)
<input type="checkbox"/> Forrest 1B (Oozing hemorrhage)	
Signs of recent hemorrhage	
<input type="checkbox"/> Forrest 2A (Visible vessel)	
<input type="checkbox"/> Forrest 2B (Adherent clot)	
<input type="checkbox"/> Forrest 2C (Hematin covered lesion)	

<b>2. Location of bleeding</b>			
<input type="checkbox"/> Esophagus	<input type="checkbox"/> Cardias	<input type="checkbox"/> Stomach	
<input type="checkbox"/> Fundus / antrum	<input type="checkbox"/> Lesser curvature	<input type="checkbox"/> Greater curvature	
<input type="checkbox"/> Duodenum	<input type="checkbox"/> Duodenal bulb		
<input type="checkbox"/> Descendant part (Please specify)			

<b>Date of intervention (dd.mm.yyyy)</b>	
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<b>Type of OTSC system</b>			
<input type="checkbox"/> Small, endoscope diameter (9.5-11,0 mm)	<input type="checkbox"/> Atraumatic	<input type="checkbox"/> Traumatic	
	<input type="checkbox"/> Atraumatic	<input type="checkbox"/> Traumatic	
<input type="checkbox"/> Medium, endoscope diameter (10.5-12,0 mm)	<input type="checkbox"/> Gastric Closure (GC) version		
	<input type="checkbox"/> Atraumatic	<input type="checkbox"/> Traumatic	
<input type="checkbox"/> Large, endoscope diameter (11.5-14,0 mm)	<input type="checkbox"/> Atraumatic	<input type="checkbox"/> Traumatic	

<b>Number of clips placed</b>		<b>Duration of clipping procedure (Minutes)</b>	
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<b>Technique used for OTSC application</b>	
<input type="checkbox"/>	Suction with cap only
<input type="checkbox"/>	Conventional instrument through working channel
<input type="checkbox"/>	OTSC Twin Grasper and suction
<input type="checkbox"/>	OTSC Anchor and suction

<b>Therapeutic success of procedure</b>	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (Please specify)

<b>Hemostatic result achieved?</b>	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (Please specify)

<b>OTSC application as primary treatment or as secondary treatment after failure of other method?</b>			
<input type="checkbox"/> Primary treatment			
<input type="checkbox"/> Secondary treatment after failure of other method (Please specify)			
<input type="checkbox"/>	Thermal coagulation	<input type="checkbox"/> Injection of catecholamine	<input type="checkbox"/> Hemostatic clip (not OTSC)
<input type="checkbox"/>	Injection of fibrin glue		<input type="checkbox"/> Argon Plasma Coagulation

<b>Sign</b>	
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## BLEEDING CONTROL FORM - PART 2 – FINAL JUDGEMENT

Si prega di compilare tutti i campi (spuntare almeno un campo per ogni domanda) ed inserire il codice di sei cifre alfanumeriche, scelto per la prima parte del form, nella casella Data record per poter ricollegare entrambe le parti del form .  
Inviare il form al Fax n. 030 3469896 o alla e-mail r.manta@ausl.mo.it, all'attenzione del Dr. Raffaele Manta

Investigator (First and last name)		Data record	
Endoscopic unit of (Name and address)			
Telefono	Fax	email	
Date of compilation			

Judgement of therapeutic success	
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Days after clips placement	
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Method used to determine procedural success	
<input type="checkbox"/>	Re-endoscopy
<input type="checkbox"/>	Other (please specify below)

Clip still in position	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not determined
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Hemostatic result achieved?	
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No (Please specify below)

Complications observed at follow-up	
<input type="checkbox"/>	No
<input type="checkbox"/>	Yes (Please specify below)

Sign	
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