Michigan Department of Health and Human Services

Monoclonal Antibody Therapy - Follow-up Report of Admission or Death Worksheet

(Short Version – For use when unique identifying number is available)

This worksheet is intended to facilitate data collection regarding the administration of monoclonal antibody (mAb) therapy provided through the Michigan Department of Health and Human Services. This form may be adapted to meet the needs of healthcare facilities. Note, revisions may occur to the electronic form resulting in differences between this worksheet and the current electronic version.

Please complete this Follow-up Report of Admission or Death for any patient who was treated with monoclonal antibody (mAb) therapy supplied through the State of Michigan. This information is being requested by the Michigan Department of Health and Human Services (MDHHS) in accordance with the Michigan Public Health Code (MCL 331.531). This questionnaire was determined to not be designed for a research purpose through consultation with the MDHHS Institutional Review Board. This form should be completed for any patient who received MAB-therapy (including at another facility) and within 14 days of the MAB-therapy administration was admitted to the hospital (for any reason) or who is known to have died.

In completing this questionnaire, you will be asked to include the unique number that was created during the submission of the MAB-Therapy Patient Profile form. This number will allow for linkage to the original Patient Profile form and avoid the need for re-entering previously supplied information. If this number is not available, this form can still be completed with the re-entry of certain demographic and clinical data. No patient identifying information should be disclosed on this form outside of the information requested. Thank you for providing this important information.

1. Hospital (or healthcare facility) who originally received MAB medication.

2. Hospital (or healthcare facility) who admistered MAB medication (if same as above, enter "same")

3. Name of person completing this form.

4. Email address of person completing this form.

5. Please assign a unique number for this patient (as described above) that will be used to facilitate future linkage to this case. Retain this number for potential future use.

6. Was a unique number entered above?
   - **X Yes**
   - ○ No

7. Was a unique number entered above?
   - ○ Hospitalized in a non-critical care unit.
   - ○ Hospitalized in a critical care unit
   - ○ Hospitalized in an unknown hospital unit.
   - ○ Not hospitalized

8. Name of the hospital patient was admitted to. If not admitted enter "N//A".

9. Date of hospital admission. Leave blank if not admitted.

10. Did the patient die?
    - ○ Yes
    - ○ No
    - ○ Unknown

11. Date of death (if known or applicable)?

12. Please provide any additional information you believe to be relevant to this use of MAT-Therapy.