Alpha-1 Canadian Registry
PHONE: 1-800-352-8186 | FAX: 416-603-5020
EMAIL: INFO@ALPHA1CANADIANREGISTRY.COM
UHN-TORONTO WESTERN HOSPITAL
399 BATHURST STREET
7 EAST RM 445
TORONTO, ON M5T2S8

*PLEASE FILL OUT THESE FORMS, SIGN, DATE, and MAIL or SCAN IT BACK TO US

Completed By: _____

Signature: _____ _____ Today's Date(dd/mmm/yy): ____ _____

Baseline Information

Registry ID # _____ Patient's Name _____ Sex: ☐M ☐F

Birthdate (d/m/y) _____ Height (cm) _____ Weight (kg) ___ __

Smoking History (Tobacco, Vape and/or Marijuana):
Ever smoked? YES / NO If yes, CURRENT / EX-SMOKER: Age Started:_____Age Stopped:_____
Average Number/day Cigarettes:_____Cigars:_____ Pipes:_____ Marijuana Joints: _____
Vaping habit (please describe): _____

Reason for Alpha-1 Antitrypsin Analysis:
☐Lung Disease ☐Liver Disease ☐Family Screening
☐Population Screening ☐Other diseases ☐Other:_____

Phenotype of Alpha-1 PI deficiency: **(please include a copy of the test results)**
Date of Diagnosis (dd/mmm/yy):_____ Alpha 1 Anti-trypsin Level: _____ (units)
☐ZZ ☐SZ ☐Other (specify):_____

Medical History of Lung Disease: ☐No ☐Yes If YES to lung disease, please check type below:

☐Chronic Bronchitis ☐Emphysema ☐ Asthma
☐Bronchiectasis ☐Other (specify):_____

Age at onset of respiratory symptoms: Years _____ Months _____

Main respiratory symptom present(circle only one):
non-productive cough
Productive cough
Dyspnea at rest
Dyspnea on exertion
Attacks of dyspnea

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Other relevant medical diagnoses (including liver):

☐No ☐Yes If **YES**, please specify below:

_____

_____

_____

Medical History (continued):

Lung Transplantation: ☐No ☐Yes Date: (dd/mm/yy) __ __ / __ __ / __ __
Lung Volume Reduction: ☐No ☐Yes Date: (dd/mm/yy) __ __ / __ __ / __ __
Liver Transplantation: ☐No ☐Yes Date: (dd/mm/yy) __ __ / __ __ / __ __
Have you ever had Pneumonia: ☐No ☐Yes, # times: __ __ ☐Unknown

CT-data:

Is any CT-scan of the Thorax available: ☐No ☐Yes Date: (dd/mm/yy) __ __ / __ __ / __ __

Treatment:

Medication for Lung Disease: ☐No ☐Yes Please list them below:

_____

_____

Long-term oxygen treatment: ☐No ☐Yes

Has the patient ever been treated by **Alpha-1 Pi Augmentation Therapy(Prolastin/Aralast/Zemaira or Glassia IV Infusions)?**

☐No ☐Yes Date:(dd/mm/yy) __ __ / __ __ / __ __

Has the patient stopped treatment?

☐No ☐Yes Date:(dd/mm/yy) __ __ / __ __ / __ __

Lung Function Testing:

*******Please provide a copy of your first available and most recent Lung Function Testing or provide the name of the physician who may have a copy of it on the medical release form!!!!**THANKS*************

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Liver Enzymes Testing: ☐No ☐Yes Date:(dd/mm/yy) __ __ / __ __ / __ __
(**please attach results if you have them**)

Abnormalities			
ALAT/SGOT	☐No	☐Yes	☐Not Done
ASAT/SGPT	☐No	☐Yes	☐Not Done
GT	☐No	☐Yes	☐Not Done
ALP/AP	☐No	☐Yes	☐Not Done

Do you see a liver specialist (Hepatologist)? ☐ No ☐ Yes

Occupational Status:

Regularly working ☐ No ☐ Yes

If ***NO***, specify reason: ☐Age ☐Liver disease ☐Lung Disease ☐Other

Please provide the name and contact info of a family member to contact in case we should lose touch:

_____

_____

****Thank you for taking the time to complete this information! if you have any questions, please contact our toll-free number:**

1-800-352-8186: **