

Baseline Participant Report

Section A

To be completed by the Participant

Personal Participant Details

Name _____

D.O.B. _____

Marital status _____

Occupation _____

Contact telephone number _____

E-mail address _____

Name and contact details of
Reporting physician _____

List any allergies _____

Date and place of treatment _____

Person-companion accompanying
You to the treatment clinic _____

Contact number of companion _____

Condition Related Details

Medical condition _____

Date of diagnosis _____

Present symptoms _____

Ambulation aids used _____

Current list of medication taken _____
Within the last month

Please list other medical illnesses, allergies and operations

Signed at (*place*)..... on (*date*)

Participant's signature _____

Participant's name in print _____

Participant's ID or Passport number _____

Section B

Physician's details

Name _____

Qualifications _____

Medical license number _____

Are you contracted with IBS? Yes No

Clinical Notes

Frontline observations

Weight _____

Pulse _____

Blood pressure _____

Temperature _____

Respiratory rate _____

Visual acuity (Snellen Chart) _____

Urinary dipstix analysis

Glycosuria _____

Ketonuria _____

Leucocytes _____

Nitrites _____

Haematuria _____

Urobilinogen _____

Frontline objective report by medical examiner

What is your assessment of the participant's mood?

What specific queries/worries does the participant express?

How were these issues addressed?

In your opinion, does the participant understand what the treatment entails?

Has the informed consent been signed? Yes No

Participant's History overview

Have you reviewed the participant's original application form, the participant's condition, medications and medical records? Yes No

Participant's physical and general examination

Review frontline observations and list any abnormal results

Does the participant use any ambulatory aids? Yes No

Is there catheter/stoma present? Yes No

Pallor/Juandice/cyanosis/oedema/lymphadenopathy? Yes No

What is the participant's nutritional status? _____

Are there any skeletal deformities?
(inspect the limbs and spine) _____

Does the participant have any bed sores? Yes No
If yes, please delineate anatomical position, size and dressing

Is there any evidence of a rash or existing skin conditions? Yes No
If yes, please delineate anatomical position, size and condition if possible

System review

(list all abnormal findings; if system "normal" indicate with NAD concentrated examination of the specific system(s) affected by the participant's condition)

Cardiovascular: _____

Respiratory: _____

GIT: _____

Musculoskeletal (please list any skeletal deformities or grade the neuromuscular conditions (1-5) on all major muscle groups: _____

Neurological

Higher functioning _____

Neck stiffness/Kernig sign _____

Abnormal movements _____

Cranial nerves (gross exam) _____

Gait _____

Romberg sign _____

Muscle wasting _____

Muscle tone _____

Reflexes _____

Sensation (soft touch, pain, proprioception and vibration sense in all major dermatomes: _____

Co-ordination (gait, past pointing, heel-shin, dysdiadiokinesis, etc.): _____

Special investigations taken at clinic

Blood tests

Stem cell therapy administration

Vial ID _____

Batch No. _____

Date on vial _____

Description on vial _____

Site(s) of injection _____

Post neonatal stem cell therapy observation (1 hour)

Document ¼ hourly observations

1st quarter obs BP: _____ Pulse: _____ Temp: _____
Allergies/AEs: _____

2nd quarter obs BP: _____ Pulse: _____ Temp: _____
Allergies/AEs: _____

3rd quarter obs BP: _____ Pulse: _____ Temp: _____
Allergies/AEs: _____

4th quarter obs BP: _____ Pulse: _____ Temp: _____
Allergies/AEs: _____

Document any comments made by the participant regarding their condition, the stem cell therapy prior, during and after administration

**DO NOT FORGET DOCUMENT THE VIAL NUMBER AND
CHECK THE PARTICIPANTS NAME AGAINST IT**

Signed at (*place*).....on (*date*)2007

Treating physician's signature _____

Treating physician's name in print _____

Treating physician's registration body _____

Treating physician's medical license number _____

IBS Participant Release Form

Clinical Notes

Twenty four (24) hour follow-up observations

Weight _____

Pulse _____

Blood pressure _____

Temperature _____

Respiratory rate _____

Visual acuity (Snellen Chart) _____

Document any comments made by the participant regarding their condition, the effects of the stem cell therapy since they last visited the Treatment clinic (24 hours earlier)

Urinary dipstix analysis

Glycosuria _____

Ketonuria _____

Leucocytes _____

Nitrites _____

Haematuria _____

Urobilinogen _____

Special investigations taken at clinic

Blood tests

Document any/all negative side effects or adverse effects the participant has experienced since their stem cell therapy

Document any/all positive events that have occurred since the participant has had their stem cell therapy (in detail, if necessary refer to the applicants original rating scales for comparison purposes)

I, Dr. (name)hereby confirm that
..... (Participant's name) can be
Released from the treatment clinic.

Signed at (*place*) On (*date*) 2007.

Treating physician's signature _____

Treating physician's name in print _____

Treating physician's registration body _____

Treating physician's medical license number _____

Signed at (*place*) On (*date*) 2007.

Participant's signature _____

Participant's name in print _____

Participant's ID or Passport number _____