

# Medical Eligibility Screening

For External Clinics

## Managing RAP Study

A Children's Hospital & Regional Medical Center  
& University of Washington Joint Research Project

**Recurrent Abdominal Pain (RAP) is defined as:** "three or more episodes of abdominal pain that occur over a period of three or more months and interfere with activities, in the absence of positive physical or laboratory findings which would explain the abdominal pain."

<b>Patient name:</b>		<b>Medical record number:</b>	
<b>Date of birth:</b>	(Age between 8-16 years old)	<b>Date of most recent GI appt:</b>	
<b>Height:</b>		<b>Weight:</b>	
<b>Sex:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male		
<b>Referring physician name:</b>			
<b>Referring clinic:</b>		<b>Physician phone number:</b>	

**Chief complaint:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Tests completed (check only those performed):

<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	ALT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Endoscopy	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Stool C. Difficile toxin
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Amalyse	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	GGTP	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Stool culture
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	AST	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	H. Pylori	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Stool ova/parasites
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	BUN / Creatinine	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Lypase	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	TTG
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	CBC w/diff	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	SBFT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	UGI
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	CT	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Serum IgA	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Ultrasound
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Other (write in:) _____				

### History positive for (check all that apply):

<input type="checkbox"/> Hematemesis	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Billious vomiting
<input type="checkbox"/> Melena	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Bloody diarrhea
<input type="checkbox"/> Hematochezia	<input type="checkbox"/> Perirectal disease	<input type="checkbox"/> Constipation
<input type="checkbox"/> Family history (write in:) _____		<input type="checkbox"/> Other (write in:) _____

Administrative use only:     eligible     not eligible    \_\_\_\_\_ (DLC initials and date)