General History and Physical Examination

Study Site Code _____ Site Patient ID _____ Study ID _____ Date _____

Patient Name _____ Weight (Kg) _____ Sex _____ M, F, MC, FS

Date of Birth _____ Breed _____ Body Score _____

TPR: Temperature: _____ Pulse: _____ Respiration: _____

Describe the presenting health status below:

Describe how long the dog has been unable to walk:

Time from first evidence of signs to referral:

Describe any specific orthopedic health concerns:

Describe any other health concerns:

Medications:

List all treatments for IVDD:

List all other drugs:

Verifying Signature: _____ Date: _____

Neurologic Exam

Study Site Code ____ Site Patient ID ____ Study ID ____ Exam Date ____

Patient Name ____

Inclusion Criteria Confirmation:

Please check to confirm that these criteria are being met:

☐ Paraplegic

☐ Absent Pain Sensation

Pelvic Limb Reflexes:

Indicate for each reflex as to the state of each reflex for each limb with either: 0, +, ++, +++; where ++ is normal, +++ is hyper/clonic

Patellar Reflex:	Withdrawal Reflex:	Proprioceptive Placing:	Perineal Reflex:
Left ____	Left ____	Left ____	____
Right ____	Right ____	Right ____	

Check if hyperesthesia is present ☐ Describe its location ____

Describe level of the cutaneous trunci reflex cut off in detail:

____

Verifying Signature: _____ Date: _____

Diagnostic Workup

Study Site Code ☐ Site Patient ID ☐ Study ID ☐ Dx Exam Date ☐

Patient Name ☐

Imaging:

What type of imaging modality was used: myelogram, MRI, CT ☐

Check if a CSF tap was performed? ☐

Check accordingly, both if necessary.

If so, please fill in the the following result

Cisternal ☐	Lumbar ☐
Cell Count ☐	Cell Count ☐
Protein Value ☐	Protein Value ☐

Describe any cytological findings here:

Describe where the lesion is located by checking all appropriate boxes:

T9/10 ☐	T12/13 ☐	L2/3 ☐
T10/11 ☐	T13/L ☐	L3/4 ☐
T11/12 ☐	L1/2 ☐	L4/5 ☐

Describe any unusual imaging findings here:

Bloodwork:

Describe any abnormalities for Chemistry and CBC panels below:

Chem

CBC

Urinary Analysis Results:

Cells ☐

Protein ☐

SG ☐

Verifying Signature: _____ Date: _____

Surgery Report

Study Site Code: Site Patient ID Study ID Surgery Date

Patient Name

Time: Trial Drug administered

Drug Code

Pre-Op

Premedication Drug dose

Induction Drug dose

Describe in detail the maintenance protocol utilized throughout the surgery:

Surgery

Indicate the location of the hemilaminectomy by checking all appropriate boxes:

T9/10 ☐	T12/13 ☐	L2/3 ☐
T10/11 ☐	T13/L1 ☐	L3/4 ☐
T11/12 ☐	L1/2 ☐	L4/5 ☐

Check if a fenestration performed ☐

If so, Indicate location of fenestrations by checking all appropriate boxes:

T9/10 ☐	T12/13 ☐	L2/3 ☐
T10/11 ☐	T13/L1 ☐	L3/4 ☐
T11/12 ☐	L1/2 ☐	L4/5 ☐

Describe in detail any findings observed during surgery:

Post-Op

Describe the post-op pain management protocol utilized following this surgery:

Please note any perioperative side effects:

Verifying Signature: _____ Date: _____

Recheck

Which recheck week is this?

Study Site Code | Site Patient ID | Study ID | Exam Date

Patient Name: | Weight:(Kg)

TPR

Temperature:

Pulse:

Respiration:

Assigned drug code:

Check if a dip stick test was performed ☐ Results:

Gait:

Check the appropriate box indicating the current gaiting ability as being:

☐	☐	☐	☐	☐
Paraplegic	Nonambulatory paraparetic	Ambulatory paraparetic	Ataxic	Normal

Pelvic Limb Reflexes / Sensation:

Indicate for each reflex as to the state of each reflex for each limb with either: 0, +, ++, +++; where ++ is normal, +++ is hyper/clonic

Patellar Reflex	Withdrawal Reflex:	Proprioceptive Placing:	Perineal Reflex:	Pain Sensation:
Left	Left	Left		Left
Right	Right	Right		Right
				Tail:

Check if hyperesthesia is presen ☐ Describe its location

Describe in detail the level of the cutaneous trunci reflex cut off

Adverse Events:

Have there been any adverse events? ☐

If so, please list and describe all events in detail on the appropriate form!

Improvements:

Check if bladder function has improved since the last visit? ☐

If so, please describe when and for how long bladder function has been improving below

Check if moter function has improved since the last visit ☐

If so, please describe when and for how long motor function has been improving below:

Verifying Signature: _____ Date: _____

Adverse Events

Check if this is a regular recheck? ☐

If so, which week is this? _____

Study Site Code _____ Site Patient ID _____ Study ID _____ Event Date _____

Patient Name _____ **Assigned drug code:** _____

Have there been any adverse events? ☐

If so, please list and describe all events in detail:
- date and time of each occurrence below
- how long each event has been occurring since last visit, etc.

Verifying Signature: _____ Date: _____

Methylprednisolone Sodium Succinate and Polyethylene Glycol in Canine Spinal Cord Injury
Drug Administration Sheet

Patient ID:_____ **Date: _____**

This document should accompany prepared and labeled medications and be given to the clinician.

The medications you have received should be labeled as bolus dose 1, CRI, and bolus dose 2. Each should contain the appropriate volume of drug. Please take a moment and verify that you have been given the appropriate volumes for:

Bolus doses: 2mL/kg
CRI dose: 0.16mL/kg/hr for 24 hours

Provided the dosages are correct, please:

1. Inject the first bolus over 15 minutes. Note start time and date: _____
2. Begin the CRI at 0.16mL/kg/hr 45 minutes after the first bolus. Note start time and date: _____ Note finish time and date: _____
3. 4hrs after the first bolus start time, briefly stop the CRI and give the second bolus over 15 minutes, then restart the CRI immediately. Note start time and date: _____

Please do not discuss the preparation of medications with the preparer

The drug preparer should sign this sheet at the time of medication delivery. The clinician responsible for the case should sign this sheet at the end of the CRI. Please keep this paperwork with the patient record until the CRI is complete and it has been signed. Once the sheet has been completed, please fax it to 919-513-7301 or scan and email it to ivddstudy@lists.ncsu.edu.

Signature of drug preparer: Signature of clinician:

_____ _____