



# The Children's Hospital of Philadelphia

Department of Pathology and Laboratory Medicine

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## Division of Anatomic Pathology

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### Anti-Enterocyte Antibody Clinical Form

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Age at onset of symptoms: \_\_\_\_\_

Age at AEA testing: \_\_\_\_\_

#### Ordering Physician information:

Name \_\_\_\_\_

Phone number \_\_\_\_\_

Address \_\_\_\_\_

Email address \_\_\_\_\_

#### Associated auto-immune disorders

Glomerulonephritis:	YES	NO
Diabetes:	YES	NO
Other (specify):	YES	NO

#### Clinical Manifestations

Diarrhea:	YES	NO	Skin Rash (specify):	YES	NO
Hematochezia:	YES	NO	Chronic cough/Asthma (specify):	YES	NO
Vomiting:	YES	NO	Family History (specify):	YES	NO
Failure to thrive:	YES	NO	Other (specify):		
Peripheral Edema:	YES	NO			
Recurrent Infections (specify):	YES	NO			
Arthralgias/Arthritis:	YES	NO			

#### Biopsy Results: (Enclose copy please)

Esophagus:

Stomach:

Duodenum/Small Bowel

Colon:

Other (kidney, skin etc.):

Treatment	Dose/KG	Duration	Response
Corticosteroids			
Cyclosporine			
Tacrolimus			
Other (specify)			

Clinical Diagnosis: