Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

TRANS-IBD Visit 1

Assessment	Notes		
Checking inclusion and exclusion criteria	Use the eligibility checklist	☐ Yes	☐ No
Informed consent	The participating adolescent and the legal guardian signed the informed consent statement	☐ Yes	☐ No
Randomisation	Based on the randomisation list prepared for the participating IBD centre	☐ Yes	☐ No
Patient education	Based on appendix '*Information sheet*' prepared for TRANS-IBD visit 1	☐ Yes	☐ No
Demographic data			
Date of birth	year. month. day	☐☐☐☐.☐☐.☐☐.	
Sex		☐ male	☐ female
Race/ Ethnicity	Based on self-declaration	☐ White ☐ Romany ☐ Asian ☐ afro American ☐ Other: ……	
Current studies		☐ primary school ☐ vocational training ☐ secondary school ☐ gymnasium school	
Housing conditions		☐house with a garden ☐ row house ☐ apartment house ☐ block of flats ☐ Other:……	
Family member living with the child in the same household		☐parent(s) ☐ brother(s) ☐grandparent(s)	
Number of brothers		☐0 ☐1 ☐2 ☐more than 2,	

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
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		if more than 2, number: …..
Family status of parents		☐ married ☐ divorced ☐ widow
Highest education level of the mother		☐ primary school ☐ vocational training ☐ secondary school ☐ college ☐ university
Highest education level of the father		☐ primary school ☐ vocational training ☐ secondary school ☐ college ☐ university
Smoking habits		☐ smoking ☐ not smoking
Medical history		
Date of the diagnosis	year. month. day	☐☐☐☐.☐☐.☐☐.
Disease type		☐ Crohn's disease ☐ ulcerative colitis
Localisation of the disease at the time of the diagnosis	In case of Crohn's disease	☐ L1: distal 1/3 ileum or limited cecal disease ☐ L2: colonic ☐ L3: ileocolonic ☐ L4a: upper disease proximal to ligament Treitz ☐ L4b: upper disease distal to ligament Treitz and proximal to distal 1/3 ileum
Behaviour of the disease at the time of the diagnosis	In case of Crohn's disease	☐ B1: nonstricturing, nonpenetrating ☐ B2: stricturing ☐ B3: penetrating
Localisation of the disease at the time of the diagnosis	In case of ulcerative colitis	☐ E1: proctitis ☐ E2: left-sided colitis

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

		☐ E3: extensive colitis ☐ E4: pancolitis	
Perianal manifestation at the time of the diagnosis	The presence of perianal fistula, abscess at the time of the diagnosis	☐ Yes	☐ No
Surgeries	Surgeries performed because of IBD	☐ Yes, if yes type: □ Proctocolectomy + IPAA □ proctocolectomy + ileostomy □ resection □ abscess drainage □ fistulotomy □ seton lacing	☐ No
Comorbidity	Every other disease, which is treated with medicine(s) or why the patient is needed to be followed up	☐ Yes, if yes:	☐ No
Date of the last endoscopy	year. month. day	□□□□.□□.□□. Type: upper/lower GI endoscopy Results:……	
Previous medications	Previous medications applied since the diagnosis		
Exclusive enteral nutrition	Consumption of only nutrition formulas for at least 6 weeks	☐ Yes	☐ No
5-ASA	Any drug formats (tablet, suppository, enema)	☐ Yes	☐ No
Steroid	Systemic steroid or budesonide preparation	☐ Yes, if yes, how many times:……	☐ No
Azathioprine		☐ Yes	☐ No
Other immunosuppressants	e.g.: 6-mercaptopurine, tacrolimus, methotrexate	☐ Yes	☐ No
Biological treatment	More answers can be marked	☐ no ☐ infliximab ☐ adalimumab ☐ vedolizumab	
Physical examination			
Body height	given in centimeter	□□□ cm	
Bodyweight	given in kilogramm	□□□ kg	

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Abdominal tenderness		☐ Yes	☐ No
Abdominal defense		☐ Yes	☐ No
Palpable abdominal mass		☐ Yes	☐ No
Perianal fistula	Presence of perianal fistula, abscess	☐ Yes	☐ No
Extraintestinal manifestations	IBD related manifestations outside the GI tract	☐ Yes, if yes, type: □ skin symptom □ joint symptom □ eye symptom □ liver symptom (PSC)	☐ No
Names of the currently taken IBD related drugs	**Drug format** (e.g.: pill, granulate, suppository)	**Drug dose** (e.g.: 1x 500 mg)	
Name of the drugs which caused any kind of side effect since the medical treatment of IBD was started		**Side effect**	
Disease activity indices have been filled out	In case of Crohn's disease: PCDAI, CDAI/ perianal CDAI In case of ulcerative Colitis: PUCAI, Mayo score	☐ Yes PCDAI:…… PUCAI:…… Mayo score:…… CDAI:…… pCDAI:……	☐ No
Health care utilisation in the previous 3 months due to IBD			
The use of urgent healthcare service at the caring gastroenterology unit	Every medical visit which was not arranged in advance with the caring gastroenterologist	☐ Yes, number:…..	☐ No
The use of urgent healthcare service in the emergency department		☐ Yes, number:…..	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Images: (abdominal ultrasound, abdominal x-ray, MRI, other)	All images in the previous 3 months, Urgent image: every image which was not arranged in advance	☐ Yes, number:….. with urgent indication:…..	☐ No
Endoscopies: (gastroduodenoscopy, colonoscopy)	All endoscopies in the previous 3 months, Urgent endoscopy: every endoscopy which was not arranged in advance	☐ Yes, number:….. with urgent indication:….. If yes, type: upper/lower GI endoscopy If yes, date: □□□□.□□.□□. Results:…….	☐ No
Surgeries	Surgeries performed because of IBD	☐ Yes, if yes type: □ Proctocolectomy + IPAA □ proctocolectomy + ileostomy □ resection □ abscess drainage □ fistulotomy □ seton lacing	☐ No
Hospital admissions	IBD related hospital admissions	☐ Yes, how many times: ……	☐ No
Length of hospitalisation	Number of days spent in hospital because of IBD altogether in the last 3 months	……. days	
Stool sample collection	For the determination of stool calprotectin level	☐ Yes, value:.....ug/g	☐ No
Serum sample collection	For the determination of ion levels, full blood count, inflammatory markers, kidney and liver functions	☐ Yes	☐ No
Sodium		☐ Yes, value:.....mmol/l	☐ No
Potassium		☐ Yes, value:.....mmol/l	☐ No
Urea nitrogen		☐ Yes, value:.....umol/l	☐ No
Creatinine		☐ Yes, value:.....mmol/l	☐ No
Total bilirubin		☐ Yes, value:.....umol/l	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Direct bilirubin		☐ Yes, value:.....umol/l	☐ No
ASAT/GOT		☐ Yes, value:.....U/l	☐ No
ALAT/GPT		☐ Yes, value:.....U/l	☐ No
Gamma GT		☐ Yes, value:.....U/l	☐ No
Alkaline Phosphatase		☐ Yes, value:.....U/l	☐ No
C-reactive protein		☐ Yes, value:.....mg/l	☐ No
Erythrocyte sedimentation rate		☐ Yes, value:.....mm/h	☐ No
White blood cell		☐ Yes, value:.....G/l	☐ No
Haemoglobin		☐ Yes, value:.....g/l	☐ No
Haematocrit		☐ Yes, value:.....%	☐ No
Thrombocyte		☐ Yes, value:.....G/l	☐ No
Albumin		☐ Yes, value:.....g/l	☐ No
Questionnaires	Questionnaires should be filled out on a separate paper individually by the participant and the parent before the visit starts.		
IBDSES-A questionnaire has been filled out		☐ Yes	☐ No
TRAQ questionnaire has been filled out		☐ Yes	☐ No
STARx-adolescent questionnaire has been filled out		☐ Yes	☐ No
STARx-parent questionnaire has been filled out		☐ Yes	☐ No
IMPACT-III questionnaire has been filled out		☐ Yes	☐ No
CACHE questionnaire has been filled out		☐ Yes	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

MARS-5 questionnaire has been filled out		☐ Yes	☐ No
Reconciliation of the next visit	Reconciliation of the TRANS-IBD Visit 2 was done, it should be held 3 months after the first one (±30 days) year. month. day	☐ Yes, date: ☐☐☐☐.☐☐.☐☐.	☐ No
Forms of the disease activity indices for the next visit have been given to the participant		☐ Yes	☐ No
Result of the balanced consultation (e.g. therapeutic suggestion, decision)			
Length of the balanced consultation (given in minutes)	…….. minutes		

…… ……

Signature and seal of the doctor (s) present during the visit **Signature and seal of the doctor (s) present during the visit**

Patient's name: _____ **Date of birth:** ___/____/____ **(TRANS-IBD code#_____)**
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ **-** ____:____

TRANS-IBD Visit 2
TRANS-IBD Visit 3
TRANS-IBD Visit 4

Assessment	**Notes**		
Patient education	Based on appendix '*Information sheet*' prepared for TRANS-IBD visit 2/3/4	☐ Yes	☐ No
Physical examination			
Body height	given in centimeter	☐☐☐ cm	
Bodyweight	given in kilogramm	☐☐☐ kg	
Abdominal tenderness		☐ Yes	☐ No
Abdominal defense		☐ Yes	☐ No
Palpable abdominal mass		☐ Yes	☐ No
Perianal fistula	Presence of perianal fistula, abscess	☐ Yes	☐ No
Extraintestinal manifestations	IBD related manifestations outside the GI tract	☐ Yes, if yes, type: □ skin symptom □ joint symptom □ eye symptom □ liver symptom (PSC)	☐ No
Names of the currently taken IBD related drugs	**Drug format** (e.g.: pill, granulate, suppository)	**Drug dose** (e.g.: 1x 500 mg)	
Name of the drugs which caused any kind of side effect since the medical treatment of IBD was started		**Side effect**	

Patient's name: _____ **Date of birth:** ___/____/____ **(TRANS-IBD code#_____)**
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Disease activity indices have been filled out	In case of Crohn's disease: PCDAI, CDAI/ perianal CDAI In case of ulcerative Colitis: PUCAI, Mayo score	☐ Yes PCDAI:…… PUCAI:…… Mayo score:…… CDAI:…… pCDAI:……	☐ No
Health care utilisation in the previous 3 months due to IBD			
The use of urgent healthcare service at the caring gastroenterology unit	Every medical visit which was not arranged in advance with the caring gastroenterologist	☐ Yes, number:…..	☐ No
The use of urgent healthcare service in the emergency department		☐ Yes, number:…..	☐ No
Images: (abdominal ultrasound, abdominal x-ray, MRI, other)	All images in the previous 3 months, Urgent image: every image which was not arranged in advance	☐ Yes, number:….. with urgent indication:…..	☐ No
Endoscopies: (gastroduodenoscopy, colonoscopy)	All endoscopies in the previous 3 months, Urgent endoscopy: every endoscopy which was not arranged in advance	☐ Yes, number:….. with urgent indication:….. If yes, type: upper/lower GI endoscopy If yes, date: □□□□.□□.□□. Results:……	☐ No
Surgeries	Surgeries performed because of IBD	☐ Yes, if yes type: □ Proctocolectomy + IPAA □ proctocolectomy + ileostomy □ resection □ abscess drainage □ fistulotomy □ seton lacing	☐ No
Hospital admissions	IBD related hospital admissions	☐ Yes, how many times: ……	☐ No
Length of hospitalisation	Number of days spent in hospital because of IBD altogether in the last 3 months	……. days	
Other IBD and non-IBD related diseases	e.g. thyroid disease, skin disease	☐ Yes, detailed……	☐ No
Serum sample collection	For the determination of ion levels, full blood count, inflammatory markers, kidney and liver functions	☐ Yes	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Sodium		☐ Yes, value:.....mmol/l	☐ No
Potassium		☐ Yes, value:.....mmol/l	☐ No
Urea nitrogen		☐ Yes, value:.....umol/l	☐ No
Creatinine		☐ Yes, value:.....mmol/l	☐ No
Total bilirubin		☐ Yes, value:.....umol/l	☐ No
Direct bilirubin		☐ Yes, value:.....umol/l	☐ No
ASAT/GOT		☐ Yes, value:.....U/l	☐ No
ALAT/GPT		☐ Yes, value:.....U/l	☐ No
Gamma GT		☐ Yes, value:.....U/l	☐ No
Alkaline Phosphatase		☐ Yes, value:.....U/l	☐ No
C-reactive protein		☐ Yes, value:.....mg/l	☐ No
Erythrocyte sedimentation rate		☐ Yes, value:.....mm/h	☐ No
White blood cell		☐ Yes, value:.....G/l	☐ No
Haemoglobin		☐ Yes, value:.....g/l	☐ No
Haematocrit		☐ Yes, value:.....%	☐ No
Thrombocyte		☐ Yes, value:.....G/l	☐ No
Albumin		☐ Yes, value:.....g/l	☐ No
Reconciliation of the next visit	Reconciliation of the TRANS-IBD Visit was done, it should be held 3 months after the current one (±30 days) year. month. day	☐ Yes, date: □□□□.□□.□□.	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Forms of the disease activity indices for the next visit have been given to the participant		☐ Yes	☐ No
Result of the balanced consultation (e.g. therapeutic suggestion, decision)			
Length of the balanced consultation (given in minutes)	..... minutes		

…… ……

Signature and seal of the doctor (s) present during the visit **Signature and seal of the doctor (s) present during the visit**

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

TRANS-IBD Visit 5
TRANS-IBD Visit 9

Demographic data		
Current studies		☐ primary school ☐ vocational training ☐ secondary school ☐ gymnasium school
Housing conditions		☐house with a garden ☐ row house ☐ apartment house ☐ block of flats ☐ Other:……
Family member living with the child in the same household		☐parent(s) ☐ brother(s) ☐grandparent(s)
Number of brothers		☐0 ☐1 ☐2 ☐more than 2, if more than 2, number: …..
Family status of parents		☐married ☐ divorced ☐ widow
Highest education level of the mother		☐ primary school ☐ vocational training ☐ secondary school ☐ college ☐ university
Highest education level of the father		☐ primary school ☐ vocational training ☐ secondary school ☐ college ☐ university
Smoking habits		☐smoking ☐ not smoking
Physical examination		

Patient's name: _____ **Date of birth:** ___/____/____ **(TRANS-IBD code#_____)**
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ **-** ____:____

Body height	given in centimeter	☐☐☐ cm	
Bodyweight	given in kilogramm	☐☐☐ kg	
Abdominal tenderness		☐ Yes	☐ No
Abdominal defense		☐ Yes	☐ No
Palpable abdominal mass		☐ Yes	☐ No
Perianal fistula	Presence of perianal fistula, abscess	☐ Yes	☐ No
Extraintestinal manifestations	IBD related manifestations outside the GI tract	☐ Yes, if yes, type: □ skin symptom □ joint symptom □ eye symptom □ liver symptom (PSC)	☐ No
Names of the currently taken IBD related drugs	**Drug format** (e.g.: pill, granulate, suppository)	**Drug dose** (e.g.: 1x 500 mg)	
Name of the drugs which caused any kind of side effect since the medical treatment of IBD was started		**Side effect**	
Disease activity indices have been filled out	In case of Crohn's disease: PCDAI, CDAI/ perianal CDAI In case of ulcerative Colitis: PUCAI, Mayo score	☐ Yes PCDAI:…… PUCAI:…… Mayo score:…… CDAI:…… pCDAI:……	☐ No
Health care utilisation in the previous 3 months due to IBD			
The use of urgent healthcare service at the caring gastroenterology unit	Every medical visit which was not arranged in advance with the caring gastroenterologist	☐ Yes, number:…..	☐ No
The use of urgent healthcare service in the emergency department		☐ Yes, number:…..	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Images: (abdominal ultrasound, abdominal x-ray, MRI, other)	All images in the previous 3 months, Urgent image: every image which was not arranged in advance	☐ Yes, number:….. with urgent indication:…..	☐ No
Endoscopies: (gastroduodenoscopy, colonoscopy)	All endoscopies in the previous 3 months, Urgent endoscopy: every endoscopy which was not arranged in advance	☐ Yes, number:….. with urgent indication:….. If yes, type: upper/lower GI endoscopy If yes, date: □□□□.□□.□□. Results:……..	☐ No
Surgeries	Surgeries performed because of IBD	☐ Yes, if yes type: □ Proctocolectomy + IPAA □ proctocolectomy + ileostomy □ resection □ abscess drainage □ fistulotomy □ seton lacing	☐ No
Hospital admissions	IBD related hospital admissions	☐ Yes, how many times: ……	☐ No
Length of hospitalisation	Number of days spent in hospital because of IBD altogether in the last 3 months	……. days	
Other IBD and non-IBD related diseases	e.g. thyroid disease, skin disease	☐ Yes, detailed……	☐ No
Stool sample collection	For the determination of stool calprotectin level	☐ Yes, value:.....ug/g	☐ No
Serum sample collection	For the determination of ion levels, full blood count, inflammatory markers, kidney and liver functions	☐ Yes	☐ No
Sodium		☐ Yes, value:.....mmol/l	☐ No
Potassium		☐ Yes, value:.....mmol/l	☐ No
Urea nitrogen		☐ Yes, value:.....umol/l	☐ No
Creatinine		☐ Yes, value:.....mmol/l	☐ No

Patient's name: _____ **Date of birth:** ___/____/____ **(TRANS-IBD code#_____)**
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ **-** ____:____

Total bilirubin		☐ Yes, value:.....umol/l	☐ No
Direct bilirubin		☐ Yes, value:.....umol/l	☐ No
ASAT/GOT		☐ Yes, value:.....U/l	☐ No
ALAT/GPT		☐ Yes, value:.....U/l	☐ No
Gamma GT		☐ Yes, value:.....U/l	☐ No
Alkaline Phosphatase		☐ Yes, value:.....U/l	☐ No
C-reactive protein		☐ Yes, value:.....mg/l	☐ No
Erythrocyte sedimentation rate		☐ Yes, value:.....mm/h	☐ No
White blood cell		☐ Yes, value:.....G/l	☐ No
Haemoglobin		☐ Yes, value:.....g/l	☐ No
Haematocrit		☐ Yes, value:.....%	☐ No
Thrombocyte		☐ Yes, value:.....G/l	☐ No
Albumin		☐ Yes, value:.....g/l	☐ No
Questionnaires	Questionnaires should be filled out on a separate paper individually by the participant and the parent before the visit starts.		
IBDSES-A questionnaire has been filled out		☐ Yes	☐ No
TRAQ questionnaire has been filled out		☐ Yes	☐ No
STARx-adolescent questionnaire has been filled out		☐ Yes	☐ No
STARx-parent questionnaire has been filled out		☐ Yes	☐ No
IMPACT-III questionnaire has been filled out		☐ Yes	☐ No
CACHE questionnaire has been filled out		☐ Yes	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

MARS-5 questionnaire has been filled out		☐ Yes	☐ No
Reconciliation of the next visit	Reconciliation of the TRANS-IBD Visit was done, it should be held 3 months after the current one (±30 days) year. month. day	☐ Yes, date: □□□□.□□.□□.	☐ No
Forms of the disease activity indices for the next visit have been given to the participant		☐ Yes	☐ No
Length of the consultation (given in minutes)	..... minutes		

.....
Signature and seal of the doctor(s) present during the visit

Patient's name: _____ **Date of birth:** ___/____/____ **(TRANS-IBD code#_____)**
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ **-** ____:____

TRANS-IBD Visit 6
TRANS-IBD Visit 7
TRANS-IBD Visit 8

Physical examination			
Body height	given in centimeter	☐☐☐ cm	
Bodyweight	given in kilogramm	☐☐☐ kg	
Abdominal tenderness		☐ Yes	☐ No
Abdominal defense		☐ Yes	☐ No
Palpable abdominal mass		☐ Yes	☐ No
Perianal fistula	Presence of perianal fistula, abscess	☐ Yes	☐ No
Extraintestinal manifestations	IBD related manifestations outside the GI tract	☐ Yes, if yes, type: □ skin symptom □ joint symptom □ eye symptom □ liver symptom (PSC)	☐ No

Names of the currently taken IBD related drugs	**Drug format** (e.g.: pill, granulate, suppository)	**Drug dose** (e.g.: 1x 500 mg)

Name of the drugs which caused any kind of side effect since the medical treatment of IBD was started	**Side effect**

Patient's name: _____ **Date of birth:** ___/____/____ **(TRANS-IBD code#_____)**
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Disease activity indices have been filled out	In case of Crohn's disease: PCDAI, CDAI/ perianal CDAI In case of ulcerative Colitis: PUCAI, Mayo score	☐ Yes PCDAI:…… PUCAI:…… Mayo score:…… CDAI:…… pCDAI:……	☐ No
Health care utilisation in the previous 3 months due to IBD			
The use of urgent healthcare service at the caring gastroenterology unit	Every medical visit which was not arranged in advance with the caring gastroenterologist	☐ Yes, number:…..	☐ No
The use of urgent healthcare service in the emergency department		☐ Yes, number:…..	☐ No
Images: (abdominal ultrasound, abdominal x-ray, MRI, other)	All images in the previous 3 months, Urgent image: every image which was not arranged in advance	☐ Yes, number:….. with urgent indication:…..	☐ No
Endoscopies: (gastroduodenoscopy, colonoscopy)	All endoscopies in the previous 3 months, Urgent endoscopy: every endoscopy which was not arranged in advance	☐ Yes, number:….. with urgent indication:….. If yes, type: upper/lower GI endoscopy If yes, date: □□□□.□□.□□. Results:……..	☐ No
Surgeries	Surgeries performed because of IBD	☐ Yes, if yes type: □ Proctocolectomy + IPAA □ proctocolectomy + ileostomy □ resection □ abscess drainage □ fistulotomy □ seton lacing	☐ No
Hospital admissions	IBD related hospital admissions	☐ Yes, how many times: ……	☐ No
Length hospitalisation	Number of days spent in hospital because of IBD altogether in the last 3 months	……. days	
Other IBD and non-IBD related diseases	e.g. thyroid disease, skin disease	☐ Yes, detailed……	☐ No
Serum sample collection	For the determination of ion levels, full blood count, inflammatory markers, kidney and liver functions	☐ Yes	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Sodium		☐ Yes, value:.....mmol/l	☐ No
Potassium		☐ Yes, value:.....mmol/l	☐ No
Urea nitrogen		☐ Yes, value:.....umol/l	☐ No
Creatinine		☐ Yes, value:.....mmol/l	☐ No
Total bilirubin		☐ Yes, value:.....umol/l	☐ No
Direct bilirubin		☐ Yes, value:.....umol/l	☐ No
ASAT/GOT		☐ Yes, value:.....U/l	☐ No
ALAT/GPT		☐ Yes, value:.....U/l	☐ No
Gamma GT		☐ Yes, value:.....U/l	☐ No
Alkaline Phosphatase		☐ Yes, value:.....U/l	☐ No
C-reactive protein		☐ Yes, value:.....mg/l	☐ No
Erythrocyte sedimentation rate		☐ Yes, value:.....mm/h	☐ No
White blood cell		☐ Yes, value:.....G/l	☐ No
Haemoglobin		☐ Yes, value:.....g/l	☐ No
Haematocrit		☐ Yes, value:.....%	☐ No
Thrombocyte		☐ Yes, value:.....G/l	☐ No
Albumin		☐ Yes, value:.....g/l	☐ No
Reconciliation of the next visit	Reconciliation of the TRANS-IBD Visit was done, it should be held 3 months after the current one (±30 days) year. month. day	☐ Yes, date: ☐☐☐☐.☐☐.☐☐.	☐ No
Forms of the disease activity indices for the next visit have been given to the participant		☐ Yes	☐ No

Patient's name: _____ Date of birth: ___/____/____ (TRANS-IBD code#_____)
Form completion date (year/month/day/ hour: minute): ____/_____/____/____:____ - ____:____

Length of the consultation (given in minutes)	…….. minutes

……
Signature and seal of the doctor(s) present during the visit