Cleveland Clinic
Laboratories

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216.444.5755 or 800.628.6816

Anti-Enterocyte Antibody Clinical Form

Patient Name: _____ **DOB:** _____

Age at onset of symptoms: _____ **Age at AEA Testing:** _____

ASSOCIATED AUTO-IMMUNE DISORDERS

Glomerulonephritis	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Other: _____	❑ Yes	❑ No

CLINICAL MANIFESTATIONS

Diarrhea	❑ Yes	❑ No	Recurrent Infections	❑ Yes	❑ No
Hematochezia	❑ Yes	❑ No	*(specify)* _____		
Vomiting	❑ Yes	❑ No	Chronic cough/Asthma	❑ Yes	❑ No
Failure to thrive	❑ Yes	❑ No	*(specify)* _____		
Peripheral Edema	❑ Yes	❑ No	Family History	❑ Yes	❑ No
Arthralgias/Arthritis	❑ Yes	❑ No	*(specify)* _____		
Skin Rash	❑ Yes	❑ No	Other	❑ Yes	❑ No
(specify) _____			*(specify)* _____		

BIOPSY RESULTS *(please enclose copy)*

Esophagus: _____

Stomach: _____

Duodenum/Small bowel: _____

Colon: _____

Other (kidneys, skin, etc.): _____

TREATMENT	Dose/KG	Duration	Response
Corticosteroids: _____			
Cyclosporine: _____			
Tacrolimus: _____			
Other (specify): _____			