REQUEST FOR PHYSICIAN CONSULTATION INSTRUCTIONS

TO: ________________________________

FROM: Regina Hockett, OA IV

THE FOLLOWING INFORMATION IS REQUIRED PRIOR TO BOOKING AN APPOINTMENT:

Patient demographics:

Up to date contact information (address, phone numbers) along with completed insurance form. We must have insurance policy holder's information included on the form to complete patients chart.

Diagnosis related records:

Ex: Test results, such as Tilt Table Test, Holter report, Lab’s, MRI’S or CT Scans, EKG’s, Urinalysis, etc., along with any other diagnosis related information.

Consult form:

This form needs to be filled out completely and signed by the referring physician.

Please check: *Requested Physician or First Available
*Diagnosis
Complete:   *Orthostatic Vitals (if applicable)
Address:    *Please print your clinic address if it is not on your fax cover sheet
Signature:  *Referring MD must sign consult form

Upon receipt of the above information your patient will be scheduled for autonomic testing and a consultation. We will notify him/her by mail with appointment date and times.

Please do not hesitate to call me if you have any questions.

Thank you for your referral!!

If you have any problems with this transmission of this fax, please call the above phone number.

Confidentiality Statement:

The documents accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

01/18/12
November 19, 2013

Dear. Referring Physician,

Thank you for your interest in the Vanderbilt Autonomic Dysfunction Clinic. Our clinic functions on a consultation basis. Please complete and sign the attached request form for your patient.

We have attached an order form for autonomic function tests and ancillary testing. The autonomic consultation will certainly be more fruitful if diagnostic test results are available at the time of the patient visit. Our physicians cannot order this testing before they see your patient. Testing ordered in advance of the visit will potentially prevent the patient from having to travel back to Nashville to have testing administered after the consultation. As such, we request you kindly take a look at the attached forms and order the appropriate testing, if you agree (check the appropriate boxes and provide your signature). The testing will then be scheduled during the same visit, minimizing the need for multiple trips to Vanderbilt for your patient.

Please let me know if you have any questions or concerns.

Thanks,
Regina Hockett
Office Assistant
Vanderbilt Autonomic Clinic
# ___________________

Request for Physician Consultation Services at VUMC
Fax completed form to 615-936-8208

You have referred _________________________________ DOB __________________________ to the Autonomic Dysfunction Clinic at the Vanderbilt University Medical Center.

Please complete this form and fax it to the attention of Regina Hockett at 615-936-8208.

Indication for Consultation (check all that apply)

__ Pre-syncope
__ Syncope
__ Orthostatic Hypotension (fall in BP>20/10 mmHg within 2 min of standing)
__ Orthostatic Tachycardia (increase in HR.30 bpm on standing)
__ Multiple System Atrophy / Shy-Drager Syndrome
__ Dysautonomia
__ Idiopathic Peripheral Autonomic Neuropathy

Autonomic Consult Requested (pick one)

__ First Available
__ Italo Biaggioni, MD
__ Danielle Cherdak, MD
__ Satish R. Raj, MD MSCI
__ David Robertson, MD
__ Cyndya Shibao, MD

________________________________                                     ___________________________________
Phone              Fax

Referring MD Address: ___________________________________
___________________________________
___________________________________
___________________________________
___________________________________

_________________________________                                                ___________________________________
Referring Physician Name (PRINT) Referring Physician Signature

Autonomic Dysfunction Clinic
Vanderbilt Heart and Vascular Institute
Medical Center East, South Tower, Suite 5209
1215 21st Avenue South
Nashville, TN 37232-8802
Phone 615-322-2318 Fax 615-936-8208
Vanderbilt Autonomic Dysfunction Center
Medical Questionnaire Part I

Today's date ________________

Name: ______________________________________________________________________

Your Blood Pressure and Heart Rate:
Please have your physician take your **blood pressure AND heart rate** while lying down and standing on three separate dates, preferably early in the morning at least 2 hours after a meal (or you can have a caregiver help you do this if you have a home blood pressure machine). **This is a very important part of our evaluation.**

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Lying down</th>
<th>Standing up for one minute</th>
<th>Standing up for three minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Measurement</td>
<td></td>
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<tr>
<td>2nd Measurement</td>
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<tr>
<td>3rd Measurement</td>
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</tr>
</tbody>
</table>
I. Contact Information

Name: ______________________________________________________________________
Age: _______                     Date of birth: ________________________________________
Home Address: ________________________________________________________________
City: _________________________ State_______________________  Zip_______________
Home phone: ___________________________    Cell phone: __________________________
Email address: ______________________________________________________________________
Occupation: _____________________________     Work phone: ________________________
Employer: ________________________________________________________________________
Sex: __ female __ male               Marital Status: __single __ married
Person to contact case of emergency (include name, home address and phone numbers):
______________________________________________________________________________
______________________________________________________________________________
________________________________________________________________________________

II. Prior Diagnosis: Has a physician ever told you that you had:

☐ Postural Tachycardia syndrome (POTS) or orthostatic intolerance or inappropriate tachycardia
  (rapid heart beat) on standing?
☐ Inappropriate Sinus Tachycardia (IST)?
☐ Pure Autonomic Failure (PAF)?
☐ Multiple System Atrophy (MSA) or Shy-Drager Syndrome (SDS)?
☐ Parkinson's Disease with orthostatic hypotension or autonomic dysfunction?
☐ Diabetes Mellitus (high blood sugar) with autonomic dysfunction?
☐ Syncope (passing our spells)
☐ Mitral Valve Prolapse (MVP)
☐ Other (please describe):

III. Current Medications

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>How often do you take it?</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Vanderbilt Autonomic Dysfunction Center
Medical Questionnaire Part II
IV. Present Illness

Explain in your own words the medical problem you have. (Use other side if you need more room).
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
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V. Drug Allergies?

_____________________________________________________________________

VI. Social History

Smoke? Y N How much?

Alcohol? Y N How much?

Drugs? Y N How much?

Occupation: ________________________________

Marital Status: ________________________________

Children? ________________________________
VII. Family History of:
Fainting  Y  N  Details ________________________________
Sudden Death  Y  N  Details ________________________________

VIII. Past/Other Medical Problems & Prior Surgeries
1. ______________________________________  5. ___________________________________
2. ______________________________________  6. ___________________________________
3. ______________________________________  7. ___________________________________
4. ______________________________________  8. ___________________________________

IX. Brief Medical Systems Review:
Do you have a problem in any of the following areas? Please provide some details for ALL Yes answers.
1. General (weight loss, weight gain)  Y  N
2. Head (headaches)  Y  N
3. Eyes (double vision, vision change)  Y  N
4. Ears/Nose/Throat (hearing loss)  Y  N
5. Heart/Blood Vessels (chest pains)  Y  N
6. Lungs (short of breath)  Y  N
7. Gastrointestinal (nausea, vomit, diarrhea, abdo pain)  Y  N
8. Genitourinary (trouble voiding, painful voiding, blood in urine)  Y  N
9. Muscle/Bone (joint pains)  Y  N
10. Neurological (neuropathy)  Y  N
11. Psych (Anxiety, Depression)  Y  N
12. Endocrine (Diabetes, Thyroid)  Y  N
13. Blood (easy bruise)/Lymph glands/Spleen  Y  N
14. General (not specifically covered elsewhere)  Y  N

Your Doctors to whom we should send reports:
(Please write name, specialty, city, phone & fax if known)
1. (PCP) __________________________________________________________________________
2. _______________________________________________________________________________
3. _______________________________________________________________________________

When was your last hospitalization?
How is your present health?  __Excellent  ___Good  ___Fair  ___Poor
Expanded Family History

Family background may be related to medical conditions. Please fill in the following chart:

<table>
<thead>
<tr>
<th>If Living Now</th>
<th>State of Health</th>
<th>If Deceased</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
<td>Age</td>
<td>(good, fair, poor)</td>
</tr>
</tbody>
</table>

Father: ________________________________________________________________________________

Mother: ________________________________________________________________________________

Brothers and Sisters, starting with the oldest (include yourself with a * by your name):

Spouse: ________________________________________________________________________________

Children: ________________________________________________________________________________

__________________________________________________________________________ ______

__________________________________________________________________________ ______

__________________________________________________________________________ ______

___________________________________________________________________________

Check in the Self column if any of the following has happened to you. Check the Relative column if any of the following have happened to a blood relative and state the relationship (mother, brother, aunt, etc.)

<table>
<thead>
<tr>
<th>Self</th>
<th>Relative</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
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<table>
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<tr>
<th>Self</th>
<th>Relative</th>
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</table>

<table>
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<tr>
<th>Autonomic Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanderbilt Heart Institute</td>
</tr>
<tr>
<td>1215 21st Avenue South</td>
</tr>
<tr>
<td>Nashville, TN 37232</td>
</tr>
<tr>
<td>FAX: 615-936-8208</td>
</tr>
<tr>
<td>Phone: 615-322-2318</td>
</tr>
</tbody>
</table>
XII. Expanded Past Medical History

1. Please check any of the following that you think you may have received greater exposure to them than average:
   - _insecticides
   - _rotenone
   - _lead
   - _organic solvents
   - _asbestos
   - _arsenic
   - _mercury
   - _other hazards (specify)

2. When was the last time you had immunizations (shots) for tetanus _______________________
   flu ___________________________
   pneumonia ______________________

3. Do you have dental problems? Explain: ____________________________________________
   _______________________________________________________________________

4. For women only: When did you last see your gynecologist for a Pap smear? _______________

5. Do you follow a special diet? ______________ If yes, please explain. ___________________
   _______________________________________________________________________

6. Check any of the following that you have had:
   - _chronic fatigue syndrome
   - _rheumatic fever
   - _measles
   - _phlebitis
   - _mononucleosis
   - _jaundice
   - _herpes
   - _pneumonia
   - _venereal disease
   - _diverticulitis
   - _hernia
   - _hemorrhoids
   - _tension/anxiety problem
   - _depression
   - _migraines
   - _irritable bowel syndrome

7. Coffee: Number of cups per day __________  
   Tea: Number of cup/glasses per day __________

8. Do you use anything to move your bowels? if yes, please explain: ______________________
   _______________________________________________________________________

9. What type and how much physical activity do you have? How frequently? _________________
   _______________________________________________________________________

Parents

Family (last name)          Father            Mother
Birthplace
Occupation (if deceased or retired, what did they do before?)

Autonomic Dysfunction Center
Danielle S. Cherdak, M.D.
Satish R Raj, M.D.
David Robertson, M.D.
Cyndya A. Shibao, M.D.
XIII. Personal History

1. Your birthplace__________________________________________________________

2. Where were you raised?____________________________________________________

3. Last school attended and year______________________________________________

4. Armed forces? (If yes, explain)______________________________________________

5. Present job: Describe the work you do, your hours, and the effect it has on you: ________________

6. Describe how you spend your day at home____________________________________

7. Earlier jobs________________________________________________________________

8. List people living with you___________________________________________________

9. What does your spouse do?__________________________________________________

10. Do you have any hobbies? If yes, what are they?______________________________

11. Do you belong to any organizations? ______ Your favorites?_____________________

12. Where and when have you traveled outside the USA?__________________________

13. How is your sleep: __good  __fair  __poor  __other

14. List the major life events or changes that you have experienced (including but not limited to serious illnesses or injuries: separation from, or deaths of persons close to you; losses of property or money; moves; unemployment; business/work crises; changes to different kind of work; family crises; marriage; births; violations of the law).

15. What major events have occurred in your life in the past year?__________________

16. Are there any major changes planned in the near future?_______________________

17. How are your coping abilities __excellent  __good  __fair  __poor

18. Who are your heroes? After whom do you model yourself? What qualities in them do you try to imitate ________________________________________________________________________
For the traits listed below, check the one word to the right of each trait that describes you best:

<table>
<thead>
<tr>
<th>Trait</th>
<th>__excess</th>
<th>__plenty</th>
<th>__minimal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competitive Drive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambitious, like to achieve</td>
<td>__usually</td>
<td>__sometimes</td>
<td>__rarely</td>
</tr>
<tr>
<td>Sense of urgency/impatience</td>
<td>__constant</td>
<td>__some</td>
<td>__rarely</td>
</tr>
<tr>
<td>Deadline oriented</td>
<td>__always</td>
<td>__sometimes</td>
<td>__rarely</td>
</tr>
<tr>
<td>Feel under pressure</td>
<td>__usually</td>
<td>__sometimes</td>
<td>__rarely</td>
</tr>
<tr>
<td>Tend to worry</td>
<td>__usually</td>
<td>__sometimes</td>
<td>__rarely</td>
</tr>
<tr>
<td>Lose sleep over problems</td>
<td>__rarely</td>
<td>__sometimes</td>
<td>__usually</td>
</tr>
<tr>
<td>Able to relax</td>
<td>__rarely</td>
<td>__sometimes</td>
<td>__usually</td>
</tr>
<tr>
<td>Interests outside of work</td>
<td>__many</td>
<td>__few</td>
<td>__rare</td>
</tr>
<tr>
<td>Family life</td>
<td>__chaotic</td>
<td>__varies</td>
<td>__stable</td>
</tr>
<tr>
<td>Get pleasure from daily activities</td>
<td>__usually</td>
<td>__sometimes</td>
<td>__rarely</td>
</tr>
</tbody>
</table>

**VI. Expanded Review of Symptoms**

We all have occasional colds, fevers, belly pains, etc. This section is not for those things. Please read each question carefully and answer by placing a check in the appropriate column. If you are in doubt, check the “?” column.

<table>
<thead>
<tr>
<th>Do you now have or have you ever had?</th>
<th>No</th>
<th>Yes</th>
<th>?</th>
<th>Do you now have or have you ever had?</th>
<th>No</th>
<th>Yes</th>
<th>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failing vision</td>
<td></td>
<td></td>
<td></td>
<td>Chronic sinusitis</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Itching eyes</td>
<td></td>
<td></td>
<td></td>
<td>Coughing spells</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Eye pain</td>
<td></td>
<td></td>
<td></td>
<td>Frequent chest colds</td>
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<td></td>
<td></td>
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<tr>
<td>Double vision</td>
<td></td>
<td></td>
<td></td>
<td>Coughing up phlegm (mucus)</td>
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<td></td>
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<tr>
<td>Difficulty hearing</td>
<td></td>
<td></td>
<td></td>
<td>Coughing up blood</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ear infection</td>
<td></td>
<td></td>
<td></td>
<td>Breathing problems</td>
<td></td>
<td></td>
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<tr>
<td>Ringing in ear</td>
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<td></td>
<td></td>
<td>An abnormal chest x-ray</td>
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<td>Sores in mouth</td>
<td></td>
<td></td>
<td></td>
<td>Shortness of breathing</td>
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<td></td>
<td></td>
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<tr>
<td>Recent change in taste</td>
<td></td>
<td></td>
<td></td>
<td>More pillows to help breathe at night</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Nosebleeds</td>
<td></td>
<td></td>
<td></td>
<td>Palpitations</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nasal stuffiness</td>
<td></td>
<td></td>
<td></td>
<td>Discomfort in the chest</td>
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<tr>
<td>Loud breathing at night</td>
<td></td>
<td></td>
<td></td>
<td>Aching muscles or joints</td>
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</tbody>
</table>

**Autonomic Clinic**
Vanderbilt Heart Institute
1215 21st Avenue South
Nashville, TN 37232
FAX: 615-322-2318
Phone: 615-322-2318
<table>
<thead>
<tr>
<th>Symptom</th>
<th>No</th>
<th>Yes</th>
<th>?</th>
<th>Symptom</th>
<th>No</th>
<th>Yes</th>
<th>?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent sore throats with fever</td>
<td></td>
<td></td>
<td></td>
<td>Painful joints</td>
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<tr>
<td>Dry mouth</td>
<td></td>
<td></td>
<td></td>
<td>Jerking of the legs during sleep</td>
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<td>Hoarse voice without a cold</td>
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<td>Back pain</td>
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<td>Back pain</td>
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<td>Painful feet</td>
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<tr>
<td>Heart murmur</td>
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<td></td>
<td></td>
<td>Any handicap</td>
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<tr>
<td>High blood pressure</td>
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<td></td>
<td></td>
<td>A persistent skin problem</td>
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<td>Low blood pressure</td>
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<td></td>
<td></td>
<td>A mole that bleeds</td>
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<tr>
<td>Cramping in legs while walking</td>
<td></td>
<td></td>
<td></td>
<td>Painful whitening of fingertips when cold</td>
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<td></td>
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<tr>
<td>A tendency to feel too hot</td>
<td></td>
<td></td>
<td></td>
<td>Difficulty swallowing</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Loss of sweating</td>
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**Do you now have or have you ever had?**

- Frequent heartburn
- Frequent indigestion
- Bloating after meals
- Increased thirst
- Loss of interest in eating
- Weight loss of over 10 pounds in the last year
- Weight gain of over 10 pounds in the last year
- Tiredness without effort
- Frequent loose or watery bowel (BM’s)
- Recent change in bowel movements
- Frequent urinations
- Burning when you urination
- Blood in urine
- Difficulty holding urine in
- Severe headaches
- Slurred speech
- Balance problem
- Hands shaking or trembling
- Weakness in muscles
- Frequent sore throats with fever
- Dry mouth
- Hoarse voice without a cold
- Back pain
- Heart murmur
- High blood pressure
- Low blood pressure
- Cramping in legs while walking
- A tendency to feel too hot
- Loss of sweating

- Excessive sweating
- Cold hands
- Frequent vomiting
- Vomiting blood
- Adominal pain
- Constipation
- Change in personality
- Any sexual problem you want movements to discuss
- Black bowel movement
- Loss of bowel control
- Pale tan bowel movements
- Bleeding from the rectum
- Rectal pain
- Urinary infections
- Trouble with memory
- Numbness in hands and feet
- Recent change in handwriting
- Fatigue
Hallucinations __ __ __ Dizzy spells or lightheadedness __ __ __
Crying spells __ __ __ Increased emotionality __ __ __

For Men Only
A slow urinary system __ __ __ Prostate problem __ __ __
Burning or discharge from penis __ __ __ Swelling, lumps or pains in your testicles __ __ __

For Women Only
Lump in breast __ __ __ Discharge from nipple __ __ __
Repeated pain during intercourse __ __ __ Persistent vaginal discharge __ __ __

Do you now have or have you ever had? No Yes ? Do you now have or have you ever had? No Yes ?
Recent trouble in menstrual periods __ ____ Apart from pregnancy, nursing or menopause, have you ever gone for 6 months without a period? __ __ __
Bleeding between periods __ __ __ Bleeding after intercourse __ __ __
Bloating before periods __ __ __ Hot flashes __ __ __
Are you pregnant or do you think you might be __ __ __ Any other serious or disabling female problems __ __ __

If still menstruating, date of last period _______________________________________________________
Number of pregnancies __________ Miscarriages ______ Stillbirths _______
Induced abortions ______ Stillbirths _______
Number of children born alive __________
Number of caesarean sections _______
Complications of pregnancy (hemorrhage, toxemia) _____________________________________________