

Intestine Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 08/31/2007

Recipient Information

Name:	<input type="text"/>	DOB:	<input type="text"/>
SSN:	<input type="text"/>	Gender:	<input type="text"/>
HIC:	<input type="text"/>	Tx Date:	<input type="text"/>
State of Permanent Residence:	<input type="text"/>		
Permanent Zip:	<input type="text"/>	-	<input type="text"/>

Provider Information

Recipient Center:	<input type="text"/>
Surgeon Name:	<input type="text"/>
UPIN#:	<input type="text"/>

Donor Information

UNOS Donor ID #:	<input type="text"/>
Donor Type:	<input type="text"/>

Patient Status

Primary Diagnosis:	<input type="text"/>
Specify:	<input type="text"/>
Secondary Diagnosis:	<input type="text"/>
Specify:	<input type="text"/>
Date of: Report or Death:	<input type="text"/>
Patient Status:	<input type="radio"/> LIVING <input type="radio"/> DEAD <input type="radio"/> RETRANSPLANTED
Primary Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Contributory Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Contributory Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>

Transplant Hospitalization:	<input type="text"/>
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Date of Admission to Tx Center:

Date of Discharge from Tx Center:

Was patient hospitalized during the last 90 days prior to the transplant admission: YES NO UNK

Medical Condition at time of transplant: IN INTENSIVE CARE UNIT
 HOSPITALIZED NOT IN ICU
 NOT HOSPITALIZED

Patient on Life Support: YES NO

- Ventilator
- Artificial Liver
- Other Mechanism, Specify

Specify:

Functional Status:

Physical Capacity: No Limitations
 Limited Mobility
 Wheelchair bound or more limited
 Not Applicable (< 1 year old or hospitalized)
 Unknown

Working for income: YES NO UNK

If No, Not Working Due To:

- If Yes:
- Working Full Time
 - Working Part Time due to Demands of Treatment
 - Working Part Time due to Disability
 - Working Part Time due to Insurance Conflict
 - Working Part Time due to Inability to Find Full Time Work
 - Working Part Time due to Patient Choice
 - Working Part Time Reason Unknown
 - Working, Part Time vs. Full Time Unknown
 - Within One Grade Level of Peers
 - Delayed Grade Level

Academic Progress:

- Special Education
- Not Applicable < 5 years old
- Status Unknown

Academic Activity Level:

- Full academic load
- Reduced academic load
- Unable to participate in academics due to disease or condition
- Not Applicable < 5 years old/ High School graduate
- Status Unknown

Source of Payment:

Primary:

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

Height: ft. in. cm %ile ST=

Weight: lbs kg %ile ST=

BMI: %ile

Previous Transplants:

Previous Transplant Organ	Previous Transplant Date	Previous Transplant Graft Fail Date

If there are any prior transplants that are not listed here, please contact the UNet Help Desk to have the transplant event added to the database by calling 800-978-4334 or by emailing unethelpdesk@unos.org.

Viral Detection:

Have any of the following viruses ever been tested for:

(HIV, CMV, HBV, HCV, EBV)

- YES NO

- HIV:** YES NO

Test

Result

- Was there clinical disease (ARC, AIDS): YES NO UNK

Antibody:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose
- Positive

RNA: Negative
 Not Done
 UNK/Cannot Disclose

CMV: YES NO

Test

Result

Was there clinical disease: YES NO UNK

IgG: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

IgM: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Nucleic Acid Testing: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Culture: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HBV: YES NO

Test

Result

Was there clinical disease: YES NO UNK

Liver Histology: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Positive

Core Antibody: Negative
 Not Done
 UNK/Cannot Disclose

Surface Antigen: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HBV DNA: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HCV: YES NO

Test

Result

Was there clinical disease: YES NO UNK

Liver Histology: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Antibody: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

RIBA: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HCV RNA: Positive
 Negative
 Not Done

UNK/Cannot Disclose

EBV:

YES NO

Test

Result

Was there clinical disease:

YES NO UNK

IgG:

Positive

Negative

Not Done

UNK/Cannot Disclose

IgM:

Positive

Negative

Not Done

UNK/Cannot Disclose

EBV DNA:

Positive

Negative

Not Done

UNK/Cannot Disclose

Total Bilirubin:

mg/dl

ST=

Serum Albumin:

g/dl

ST=

Serum Creatinine:

mg/dl

ST=

Malignancies between listing and transplant:

YES NO UNK

This question is NOT applicable for patients receiving living donor transplants who were never on the waiting list.

If yes, specify type:

Skin Melanoma

Skin Non-Melanoma

CNS Tumor

Genitourinary

Breast

Thyroid

Tongue/Throat/Larynx

Lung

Leukemia/Lymphoma

Liver

Other, specify

Specify:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Information:

Intestine Only Venous Drainage:

Portal Systemic

Native Viscera Venous Drainage:

Portal Systemic

Procedure Type:

Whole Intestine

Intestine Segment

Whole Intestine with Pancreas (Technical Reasons)

Intestine Segment with Pancreas (Technical Reasons)

Organ Type:

Stomach

Small Intestine

Duodenum

Large Intestine

Preservation Information:

Total Ischemic Time (include cold, warm and anastomotic time):

hrs

ST=

Risk Factors:

Recent Septicemia:

YES NO UNK

Exhausted Vascular Access:

YES NO UNK

Liver Dysfunction:

YES NO UNK

Previous Abdominal Surgery:

YES NO UNK

Number Previous Abdominal Surgeries:

ST=

Dilated/Non-Functional Bowel Segments:

YES NO UNK

Other:

Clinical Information : POST TRANSPLANT

Graft Status:

Functioning Failed

If death is indicated for the recipient, and the death was a result of some other factor unrelated to graft failure, select Functioning.

TPN Dependent:

YES NO

IV Dependent:

YES NO

Oral Feeding:

YES NO

Tube Feed:

YES NO

Date of Graft Failure:

RECURRENT TUMOR

ACUTE REJECTION

CHRONIC REJECTION

Primary Cause of Graft Failure:

TECHNICAL PROBLEMS

INFECTION

LYMPHOPROLIFERATIVE DISEASE

OTHER SPECIFY

Specify:

Did patient have any acute rejection episodes between transplant and discharge:

Yes, at least one episode treated with anti-rejection agent

Yes, none treated with additional anti-rejection agent

No

Biopsy not done

Was biopsy done to confirm acute rejection:

Yes, rejection confirmed

Yes, rejection not confirmed

Treatment

Biological or Anti-viral Therapy:

YES NO Unknown/Cannot disclose

Acyclovir (Zovirax)

Cytogam (CMV)

Gamimune

If Yes, check all that apply:

Gammagard

Ganciclovir (Cytovene)

Valgancyclovir (Valcyte)

HBIG (Hepatitis B Immune Globulin)

Flu Vaccine (Influenza Virus)

Lamivudine (Epivir) (for treatment of Hepatitis B)

Other, Specify

Valacyclovir (Valtrex)

Specify:

Specify:

Other therapies:

YES NO

Photopheresis

If Yes, check all that apply:

Plasmapheresis

Total Lymphoid Irradiation (TLI)

Immunosuppressive Information

Are any medications given currently for maintenance or anti-rejection:

YES NO

Did the patient participate in any clinical research protocol for immunosuppressive medications:

YES NO

If Yes, Specify:

Immunosuppressive Medications

View Immunosuppressive Medications

Definitions Of Immunosuppressive Medications

For each of the immunosuppressive medications listed, select **Ind** (Induction), **Maint** (Maintenance) or **AR** (Anti-rejection) to indicate all medications that were prescribed for the recipient during the initial transplant hospitalization period, and for what reason. If a medication was not given, leave the associated box(es) blank.

Induction (Ind) immunosuppression includes all medications given for a short finite period in the perioperative period for the purpose of preventing acute rejection. Though the drugs may be continued after discharge for the first 30 days after transplant, it will not be used long-term for immunosuppressive maintenance. Induction agents are usually polyclonal, monoclonal, or IL-2 receptor antibodies (example: Methylprednisolone, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as rejection therapy if used for this reason. For each induction medication indicated, write the total number of days the drug was actually administered in the space provided. For example, if Simulect or Zenapax was given in 2 doses a week apart, then the total number of days would be 2, even if the second dose was given after the patient was discharged.

Maintenance (Maint) includes all immunosuppressive medications given before, during or after transplant *for varying periods of time which may be either long-term or intermediate term with a tapering of the dosage until the drug is either eliminated or replaced by another long-term maintenance drug* (example: Prednisone, Cyclosporine, Tacrolimus, Mycophenolate Mofetil, Azathioprine, or Rapamycin). This does not include any immunosuppressive medications given to treat rejection episodes, or for induction.

Anti-rejection (AR) immunosuppression includes all immunosuppressive medications given for the purpose of treating an acute rejection episode during the initial post-transplant period or during a specific follow-up period, usually up to 30 days after the diagnosis of acute rejection (example: Methylprednisolone, Atgam, OKT3, or Thymoglobulin). When switching maintenance drugs (example: from Tacrolimus to Cyclosporine; or from Mycophenolate Mofetil to Azathioprine) because of rejection, the drugs should not be listed under AR immunosuppression, but should be listed under maintenance immunosuppression.

If an immunosuppressive medication other than those listed is being administered (e.g., new monoclonal antibodies), select Ind, Maint, or AR next to Other Immunosuppressive Medication field, and enter the full name of the medication in the space provided. **Do not list non-immunosuppressive medications.**

Ind. Days

ST

Steroids

(Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Atgam (ATG)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
OKT3 (Orthoclone, Muromonab)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Thymoglobulin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Simulect - Basiliximab	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Zenapax - Daclizumab	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Azathioprine (AZA, Imuran)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
EON (Generic Cyclosporine)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Gengraf (Abbott Cyclosporine)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other generic Cyclosporine, specify brand:	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Neoral (CyA-NOF)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Sandimmune (Cyclosporine A)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Mycophenolate Mofetil (MMF, Cellcept, RS61443)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Tacrolimus (Prograf, FK506)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Sirolimus (RAPA, Rapamycin, Rapamune)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Myfortic (Mycophenolate Sodium)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>

Other Immunosuppressive Medications				
	Ind.	Days	ST	Maint AR
Campath - Alemtuzumab (anti-CD52)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>
Cyclophosphamide (Cytoxan)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>
Leflunomide (LFL)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>
Rituximab	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>

Other Immunosuppressive Medication, Specify

Other Immunosuppressive Medication, Specify

Investigational Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Everolimus (RAD, Certican)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
FTY 720	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>