

Kidney-Pancreas Transplant Recipient Follow-Up 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"/>
Previous Follow-Up:	<input type="text"/>	Previous Px Stat Date:	<input type="text"/>

Transplant Discharge Date:	<input type="text"/>
State of Permanent Residence:	<input type="text"/>
Zip Code:	<input type="text"/> - <input type="text"/>

Provider Information

Recipient Center:	<input type="text"/>
Followup Center:	<input type="text"/>

Physician Name:	<input type="text"/>
UPIN#:	<input type="text"/>
Follow-up Care Provided By:	<p><input type="radio"/> Transplant Center</p> <p><input type="radio"/> Non Transplant Center Specialty Physician</p> <p><input type="radio"/> Primary Care Physician</p> <p><input type="radio"/> Other Specify</p>
Specify:	<input type="text"/>

Donor Information

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

Patient Status

Date: Last Seen, Retransplanted or Death	<input type="text"/>
Patient Status:	<p><input type="radio"/> LIVING</p> <p><input type="radio"/> DEAD</p> <p><input type="radio"/> RETRANSPLANTED</p>
If Retransplanted, choose organ(s):	<p><input type="radio"/> Kidney <input type="radio"/> Pancreas <input type="radio"/> Kidney/Pancreas</p>

Primary Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
	<input type="text"/>

Contributory Cause of Death:

Specify:

Contributory Cause of Death:

Specify:

Hospitalizations:

Has the patient been hospitalized since the last patient status date:

YES NO UNK

Number of Hospitalizations:

St=

Noncompliance:

Was there evidence of noncompliance with immunosuppression medication during this follow-up period that compromised the patient's recovery:

YES NO UNK

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

Academic Progress:

- Within One Grade Level of Peers
- Delayed Grade Level
- 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

Primary Insurance at Follow-up:

Specify:

Clinical Information

Height: ft. in. cm **%ile St=**

Weight: lbs. kg **%ile St=**

BMI: **%ile**

Urine Protein Found By Any Method: YES NO UNK

Kidney 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.

Kidney Date of Failure:

- Acute Rejection
- Primary Failure
- Graft Thrombosis
- Infection

Kidney Primary Cause of Graft Failure:

- Urological Complications
- Recurrent Disease
- Chronic Rejection
- BK (Polyoma) Virus
- Other, Specify

Specify

Contributory causes of graft failure:

Kidney Acute Rejection YES NO UNK

Kidney Chronic Rejection YES NO UNK

Kidney Graft Thrombosis YES NO UNK

Kidney Infection YES NO UNK

Urological Complications YES NO UNK

Patient Noncompliance YES NO UNK

Recurrent Disease: YES NO UNK

BK (Polyoma) Virus YES NO UNK

Kidney Other Contributory Cause of Graft Failure

Most Recent Serum Creatinine: mg/dl St=

Dialysis Since Last Follow-Up: NO
 YES, RESUMED MAINTENANCE DIALYSIS
 YES, NO MAINTENANCE RESUMPTION
 YES, MAINTENANCE RESUMPTION UNKNOWN
 UNKNOWN

Date Maintenance Dialysis Resumed:

Select a Dialysis Provider:

Provider #:

Provider Name:

Pancreas Graft Status: Functioning Partial Function Failed

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

Method of blood sugar control: Insulin
 Oral medication
 Diet
 No Treatment

Date insulin/medication resumed:

Pancreas Date of Failure

Pancreas Graft Removed: YES NO UNK

Date Pancreas Removed:

Pancreas Primary Causes of Graft Failure

Specify:

Contributory causes of graft failure:

Pancreas Graft/Vascular Thrombosis

YES NO UNK

Pancreas Infection

YES NO UNK

Pancreas Bleeding

YES NO UNK

Anastomotic Leak

YES NO UNK

Pancreas Rejection: Acute

YES NO UNK

Pancreas Chronic Rejection

YES NO UNK

Biopsy Proven Isletitis

YES NO UNK

Pancreatitis

YES NO UNK

Patient Noncompliance

YES NO UNK

Other, Specify:

Conv. From Bladder to Enteric Drain Performed:

YES NO UNK

Enteric Drain Date:

Serum Amylase:

 u/L

St=

Pancreas Transplant Complications (Not leading to graft failure):

Pancreatitis

YES NO UNK

Anastomotic Leak

YES NO UNK

Abcess or Local Infection

YES NO UNK

Other, Specify:

Did patient have any kidney acute rejection episodes during the follow-up period:

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

Yes, none treated with additional anti-rejection agent

No

Unknown

Was biopsy done to confirm acute rejection:

Biopsy not done

Yes, rejection confirmed

Yes, rejection not confirmed

Unknown

Did patient have any pancreas acute rejection episodes during the follow-up period:

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

Yes, none treated with additional anti-rejection agent

No

Unknown

Was biopsy done to confirm acute rejection:

Biopsy not done

Yes, rejection confirmed

Yes, rejection not confirmed

Unknown

Viral Detection:

Were any of the following viruses diagnosed for onset or recurrence during this follow-up period:(HIV, CMV, HBV, HCV, EBV, BK)

YES NO

HIV

YES NO

Test

Result

Was there clinical disease (ARC,AIDS):

YES NO UNK

Antibody:

Positive

Negative

Not Done

UNK/Cannot Disclose

RNA:

Positive

Negative

Not Done

UNK/Cannot Disclose

CMV

YES NO

Test

Result

Was there clinical disease:

YES NO UNK

IgG:

Positive

Negative

IgM:

- Not Done
- UNK/Cannot Disclose
- 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

Core Antibody:

- Positive
- 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

BK

- YES NO

Was there clinical disease:

- YES NO UNK

Kidney Histology:

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

DNA(PCR) Testing:

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

Urine Cytology:

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

Postransplant Malignancy:

- YES NO UNK

Donor Related:

- YES NO UNK

Recurrence of Pre-Tx Tumor:

- YES NO UNK

De Novo Solid Tumor:

- YES NO UNK

De Novo Lymphoproliferative disease and Lymphoma:

- YES NO UNK

Treatment

Biological or Anti-viral therapy:

YES NO Unknown/Cannot disclose

Acyclovir (Zovirax)

Cytogam (CMV)

Gamimune

Gammagard

Ganciclovir (Cytovene)

Valgancyclovir (Valcyte)

HBIG (Hepatitis B Immune Globulin)

Flu Vaccine (Influenza Virus)

Lamivudine (Epivir) (for treatment of Hepatitis B)

Valacyclovir (Valtrex)

Other, Specify

If Yes, check all that apply:

Specify:

Specify:

Treatment for BK (polyoma) virus:

YES NO

Yes, Immunosuppression reduction

Yes, Cidofavir

Yes, IVIG

Yes, Type Unknown

Yes, Other, Specify

If Yes, check all that apply:

Specify:

Other therapies:

YES NO

Photopheresis

Plasmapheresis

Total Lymphoid Irradiation (TLI)

If Yes, check all that apply:

Immunosuppressive Information

Previous Validated Maintenance Follow-Up Medications:

Were any medications given during the follow-up period for maintenance:

Yes, same as previous validated report

Yes, but different than previous validated report

None given

Did the physician discontinue all maintenance immunosuppressive medications:

YES NO

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

YES NO

Specify:

Immunosuppressive Medications

View Immunosuppressive Medications

Definitions Of Immunosuppressive Follow-Up Medications

For each of the immunosuppressant medications listed, check **Previous Maintenance (Prev Maint)**, **Current Maintenance (Curr Maint)** or **Anti-rejection (AR)** to indicate all medications that were prescribed for the recipient during this follow-up period, and for what reason. If a medication was not given, leave the associated box(es) blank.

Previous Maintenance (Prev Maint) includes all immunosuppressive medications given during the report period, which covers the period from the last clinic visit to the current clinic visit, *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.

Current Maintenance (Curr Maint) includes all immunosuppressive medications given at the current clinic visit to begin in the next report *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.

Anti-rejection (AR) immunosuppression includes all immunosuppressive medications given for the purpose of treating an acute rejection episode since the last clinic visit (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.

Note: The Anti-rejection field refers to any anti-rejection medications since the last clinic visit, not just at the time of the current clinic visit.

If an immunosuppressive medication other than those listed is being administered (e.g., new monoclonal antibodies), select Previous Maint, or Current 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.**

	Prev Maint	Curr Maint	AR
Steroids (Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atgam (ATG)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
OKT3 (Orthoclone, Muromonab)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Thymoglobulin	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Simulect - Basiliximab	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Zenapax - Daclizumab	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Azathioprine (AZA, Imuran)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
EON (Generic Cyclosporine)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Gengraf (Abbott Cyclosporine)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other generic Cyclosporine, specify brand:	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Neoral (CyA-NOF)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sandimmune (Cyclosporine A)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mycophenolate Mofetil (MMF, Cellcept, RS61443)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Tacrolimus (Prograf, FK506)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sirolimus (RAPA, Rapamycin, Rapamune)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Myfortic (Mycophenolate Sodium)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Other Immunosuppressive Medications

	Prev Maint	Curr Maint	AR
Campath - Alemtuzumab (anti-CD52)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cyclophosphamide (Cytoxan)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Leflunomide (LFL)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rituximab	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other Immunosuppressive Medication, Specify <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Immunosuppressive Medication, Specify <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Investigational Immunosuppressive Medications

	Prev Maint	Curr Maint	AR
Everolimus (RAD, Certican)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
FTY 720	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>