

# Records

## Kidney Transplant Recipient Follow-Up Worksheet

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

Recipient Information	
Name:	DOB:
SSN:	Gender:
HIC:	Tx Date:
Previous Follow-Up:	Previous Px Stat Date:
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:	
Followup Center:	
Physician Name:	<input type="text"/>
UPIN#:	<input type="text"/>
Follow-up Care Provided By:	<input type="radio"/> Transplant Center <input type="radio"/> Non Transplant Center Specialty Physician <input type="radio"/> Primary Care Physician <input type="radio"/> Other Specify
Specify:	<input type="text"/>

Donor Information	
UNOS Donor ID #:	
Donor Type:	

Patient Status	
Date: Last Seen, Retransplanted 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:

Specify:

Hospitalizations:

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

YES  NO  UNK

Number of Hospitalizations:

St=

TRR  
Diagnosis:

Disease Recurrence:

- No recurrence
- Suspected recurrence (not confirmed or unknown is confirmed by biopsy)
- Biopsy confirmed recurrence
- Unknown

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

**Diabetes during the follow-up period:**

- YES
- NO
- UNK

If yes, insulin dependent:

- YES
- NO
- UNK

**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.

**If Functioning, Most Recent Serum Creatinine:**

 mg/dl St= 

**Date of Failure:**

**Primary Cause of Graft Failure:**

- Acute Rejection
- Primary Failure
- Graft Thrombosis
- Infection
- Urological Complications
- Recurrent Disease

Chronic Rejection

BK (Polyoma) Virus

Other, Specify

Other, Specify:

**Contributory causes of graft failure:**

**Acute Rejection**

YES  NO  UNK

**Chronic Rejection**

YES  NO  UNK

**Graft Thrombosis**

YES  NO  UNK

**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

Other, Specify:

NO

YES, RESUMED MAINTENANCE DIALYSIS

YES, NO MAINTENANCE RESUMPTION

YES, MAINTENANCE RESUMPTION UNKNOWN

UNKNOWN

**Dialysis Since Last Follow-Up:**

**Date Maintenance Dialysis Resumed:**

**Select a Dialysis Provider:**

**Provider #:**

**Provider Name:**

**Did patient have any 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

Biopsy not done

Was biopsy done to confirm acute rejection:

- 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

Not Done

UNK/Cannot Disclose

IgM:

Positive

Negative

Not Done

UNK/Cannot Disclose

Nucleic Acid Testing:

Positive

Negative

Culture:

- Not Done
- UNK/Cannot Disclose
- 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

**Post Transplant Malignancies:**

YES  NO  UNK

**Donor Related:**

YES  NO  UNK

**Recurrence of Pre-Tx Tumor:**

YES  NO  UNK

**Post Tx 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

If Yes, check all that apply:

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

Specify:

Specify:

Treatment for BK (polyoma) virus:

YES  NO

Yes, Immunosuppression reduction

Yes, Cidofovir

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="text"/>	<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"/>

<b>Investigational Immunosuppressive Medications</b>			
	<b>Prev Maint</b>	<b>Curr Maint</b>	<b>AR</b>
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"/>