

## Liver Transplant Recipient Registration Worksheet

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

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

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

Donor Information	
UNOS Donor ID #:	
Donor Type:	

Patient Status	
Primary 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:	
Date of Admission to Tx Center:	<input type="text"/>
Date of Discharge from Tx Center:	<input type="text"/>

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

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

**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

Positive

Negative

Not Done

UNK/Cannot Disclose

Positive

Negative

RNA:

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

Core Antibody:

Positive

Negative

Not Done

- Surface Antigen:
- UNK/Cannot Disclose
  - Positive
  - Negative
  - Not Done
  - UNK/Cannot Disclose
- Surface Antibody:
- Positive
  - Negative
  - Not Done
  - UNK/Cannot Disclose
- E Antigen:
- Positive
  - Negative
  - Not Done
  - UNK/Cannot Disclose
- HBV DNA:
- Positive
  - Negative
  - Not Done
  - UNK/Cannot Disclose
- HDV (Delta Virus):
- 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

- RIBA:  UNK/Cannot Disclose  
 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: | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK  |
| IgG:                        | <input type="radio"/> Positive<br><input type="radio"/> Negative<br><input type="radio"/> Not Done<br><input type="radio"/> UNK/Cannot Disclose |
| IgM:                        | <input type="radio"/> Positive<br><input type="radio"/> Negative<br><input type="radio"/> Not Done<br><input type="radio"/> UNK/Cannot Disclose |
| EBV DNA:                    | <input type="radio"/> Positive<br><input type="radio"/> Negative<br><input type="radio"/> Not Done<br><input type="radio"/> UNK/Cannot Disclose |

**Any tolerance induction technique used:**  YES  NO  UNK

**Pretransplant Lab Date:**

**SGPT/ALT:**  U/L **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:

Surgical Procedure:

- ORTHOTOPIC
- HETEROTOPIC
- Whole Liver
- Partial Liver, remainder not Tx or Living Transplant
- Split Liver
- Whole Liver with Pancreas (Technical Reasons)
- Partial Liver with Pancreas (Technical Reasons)
- Split Liver with Pancreas (Technical Reasons)

Procedure Type:

Split Type:

Preservation Information:

Warm Ischemia Time (include anastomotic time):

 min

ST=

Total Cold Ischemia Time (if pumped, include pump time):

 hrs

ST=

Risk Factors:

Did Patient receive 5 or more units of packed red blood cells within 48 hours prior to transplantation due to spontaneous portal hypertensive bleeding:

- YES
- NO
- UNK

Spontaneous Bacterial Peritonitis:

- YES
- NO
- UNK

Previous Abdominal Surgery:  YES  NO  UNK

Portal Vein Thrombosis:  YES  NO  UNK

Transjugular Intrahepatic Portacaval Stint Shunt:  YES  NO  UNK

Incidental Tumor found at time of Transplant:  YES  NO  UNK

Hepatocellular Adenoma

Hemangioma

Hemangioendothelioma

Angiomyolipoma

Bile Duct Cystadenocarcinoma

Cholangiocarcinoma

Hepatocellular Carcinoma

Hepatoblastoma

Angiosarcoma

Other Primary Liver Tumor, Specify

If yes, specify tumor type:

Specify:

### Clinical Information : POST TRANSPLANT

Pathology Conf. Liver Diag. of Hospital Discharge:

Specify:

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.

Date of Graft Failure:

Causes of graft failure:

Primary Graft Failure  YES  NO  UNK

Vascular Thrombosis  YES  NO  UNK

Biliary Tract Complication  YES  NO  UNK

Hepatitis: DeNovo  YES  NO  UNK

Hepatitis: Recurrent  YES  NO  UNK

Recurrent Disease (non-Hepatitis)  YES  NO  UNK

Acute Rejection  YES  NO  UNK

Infection

YES  NO  UNK

Other, Specify:

Discharge Lab Date:

Total Bilirubin:

 mg/dl

ST=

SGPT/ALT:

 U/L

ST=

Serum Albumin:

 g/dl

ST=

Serum Creatinine:

 mg/dl

ST=

INR:

ST=

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

Gammagard

Ganciclovir (Cytovene)

If Yes, check all that apply:

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 type="text"/>	<input checked="" type="checkbox"/> <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 <input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Immunosuppressive Medication, Specify <input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Investigational Immunosuppressive Medications**

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

