

Thoracic - Heart 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:	
Physician Name:	<input type="text"/>
Physician UPIN#:	<input type="text"/>
Surgeon Name:	<input type="text"/>
Surgeon 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:

Date of Discharge from Tx Center:

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

Medical Condition: IN INTENSIVE CARE UNIT
 HOSPITALIZED NOT IN ICU
 NOT HOSPITALIZED

Patient on Life Support: YES NO

- Extra Corporeal Membrane Oxygenation
- Intra Aortic Balloon Pump
- Prostaglandins
- Intravenous Inotropes
- Inhaled NO
- Ventilator
- Other Mechanism

Specify:

Patient on Ventricular Assist Device NONE
 LVAD
 RVAD
 TAH
 LVAD+RVAD

Life Support: VAD Brand1

Specify:

Life Support: VAD Brand2

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
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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

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

Positive

IgM:

Negative

Not Done

UNK/Cannot Disclose

Positive

Nucleic Acid Testing:

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

Antibody:

- Not Done
- UNK/Cannot Disclose
- 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

EBV DNA:

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

Most Recent Hemodynamics:

Inotropes/Vasodilators:

PA (sys)mm/Hg:

ST=

- YES
- NO

PA(dia) mm/Hg:

ST=

- YES
- NO

PA(mean) mm/Hg:

ST=

- YES
- NO

PCW(mean) mm/Hg:

ST=

- YES
- NO

CO L/min:

ST=

YES NO

Most Recent Serum Creatinine:

mg/dl

ST=

Most Recent Total Bilirubin:

mg/dl

ST=

Chronic Steroid Use:

YES NO UNK

Events occurring between listing and transplant:

Transfusions:

YES NO UNK

Pulmonary Embolism:

YES NO UNK

Infection Requiring IV Therapy within 2 wks prior to Tx:

YES NO UNK

Cerebrovascular Event:

YES NO UNK

Dialysis:

YES NO UNK

Implantable Defibrillator:

YES NO UNK

Prior Cardiac Surgery (non-transplant):

YES NO UNK

CABG

Valve Replacement/Repair

Congenital

Left Ventricular Remodeling

Other, specify

If yes, check all that apply:

Specify:

Prior Lung Surgery (non-transplant):

YES NO UNK

Pneumoreduction

Pneumothorax Surgery-Nodule

Pneumothorax Decortication

Lobectomy

Pneumonectomy

Left Thoracotomy

Right Thoracotomy

If yes, check all that apply:

Other, specify

Specify:

Episode of Ventilatory Support:

YES NO UNK

At time of transplant

If yes, indicate most recent timeframe:

Within 3 months of transplant

>3 months prior to transplant

Previous Pregnancies:

NO PREVIOUS PREGNANCY

1 PREVIOUS PREGNANCY

2 PREVIOUS PREGNANCIES

3 PREVIOUS PREGNANCIES

4 PREVIOUS PREGNANCIES

5 PREVIOUS PREGNANCIES

MORE THAN 5 PREVIOUS PREGNANCIES

NOT APPLICABLE: < 10 years old

UNKNOWN

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.

Skin Melanoma

Skin Non-Melanoma

CNS Tumor

Genitourinary

Breast

Thyroid

Tongue/Throat/Larynx

Lung

Leukemia/Lymphoma

Liver

Other, specify

If yes, specify type:

Specify:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Type:

- Heart
- Heart Lung

Heart Procedure:

- Orthotopic Bicaval
- Orthotopic Traditional
- Orthotopic Total (Bicaval, PV)
- Heterotopic

Was this a retransplant due to failure of a previous thoracic graft:

- YES
- NO

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

Heart, Heart-Lung: min ST=

Left Lung: min ST=

Right Lung (OR EN-BLOC): min ST=

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.

Date of Graft Failure:

Primary Cause of Graft Failure:

- Primary Non-Function
- Acute Rejection
- Chronic Rejection/Atherosclerosis

Events Prior to Discharge:

Any Drug Treated Infection: YES NO UNK

Stroke: YES NO UNK

Dialysis: YES NO UNK

Cardiac Re-Operation: YES NO UNK

Other Surgical Procedures: YES NO UNK

Time on inotropes other than Isoproterenol (Isuprel): days ST=

Permanent Pacemaker: YES NO UNK

Chest drain >2 weeks: YES NO UNK

Airway Dehiscence:

YES NO UNK

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 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)

Mycophenolate Mofetil (MMF, Cellcept, RS61443)

Tacrolimus (Prograf, FK506)

Sirolimus (RAPA, Rapamycin, Rapamune)

Myfortic (Mycophenolate Sodium)

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 (Cytosan)	<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"/>
FTY 720	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>