

### Thoracic - Heart/Lung 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
- Prostacyclin Infusion
- Prostacyclin Inhalation
- 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:**

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

Full academic load

Reduced academic load

**Academic Activity Level:**

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

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=**

**Oxygen Requirement at Rest:**  L/min **ST=**

**Chronic Steroid Use:**  YES  NO  UNK

**Pulmonary Status (Give most recent value):**

**FVC:**  %predicted: **ST=**

**FeV1:**  %predicted: **ST=**

**pCO2:**  mm/Hg: **ST=**

**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

If yes, check all that apply:

- Pneumothorax Surgery-Nodule
- Pneumothorax Decortication
- Lobectomy
- Pneumonectomy
- Left Thoracotomy
- Right Thoracotomy
- Other, specify

Specify:

**Episode of Ventilatory Support:**

YES  NO  UNK

If yes, indicate most recent timeframe:

- At time of transplant
- Within 3 months of transplant
- >3 months prior to transplant

**Tracheostomy:**

YES  NO  UNK

**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.

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 Type:
- Heart
  - Heart Lung
- 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:	<input type="text"/> min	ST= <input type="text"/>
Left Lung:	<input type="text"/> min	ST= <input type="text"/>
Right Lung (OR EN-BLOC):	<input type="text"/> min	ST= <input type="text"/>

Incidental Tumor found at time of Transplant:

- YES
- NO
- UNK

If yes, specify tumor type:

- Adenoma
- Carcinoma
- Carcinoid
- Lymphoma
- Harmartoma
- Other Primary Lung Tumor, Specify

Specify:

### 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=

Ventilator Support:

No

Ventilator support for <= 48 hours

Ventilator support for >48 hours but < 5 days

Ventilator support >= 5 days

Ventilator support, duration unknown

Unknown Status

Reintubated:

YES  NO  UNK

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

Was biopsy done to confirm acute rejection:

Biopsy not done

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)

Valgancyclovir (Valcyte)

HBIG (Hepatitis B Immune Globulin)

Flu Vaccine (Influenza Virus)

Lamivudine (Epivir) (for treatment of Hepatitis B)

Other, Specify

Valacyclovir (Valtrex)

If Yes, check all that apply:

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"/>	<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"/>
			<input type="text"/>	

Cyclophosphamide (Cytoxan)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leflunomide (LFL)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rituximab	<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"/>
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 type="checkbox"/>
FTY 720	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>