

# Records

## Thoracic - Lung 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=

Hospitalized for Rejection:

YES  NO  UNK

Hospitalized for Infection:

YES  NO  UNK

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

**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 Non-Function

**Primary Cause of Graft Failure:**  Acute Rejection

Chronic Rejection/Atherosclerosis

**Graft Function:**

**Lung:**

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

**O2 Requirement at Rest:**  L/min **ST=**

NO BOS

Yes, Grade OP

Yes, Grade 1

**Bronchiolitis Obliterans Syndrome:**  Yes, Grade 2

Yes, Grade 3

Yes, Grade UNK

Unknown

Bronchial Stricture (Since last follow-up):

YES  NO  UNK

If yes, Stent:

YES  NO  UNK

**Post Transplant Events:**

Drug Treated Hypertension:

YES  NO  UNK

Bone Disease (Symptomatic):

YES  NO  UNK

Chronic Liver Disease:

YES  NO  UNK

Cataracts:

YES  NO  UNK

Diabetes:

YES  NO  UNK

Diabetes: If Yes, Insulin Dependent:

YES  NO  UNK

Renal Dysfunction:

YES  NO  UNK

If Yes, Creatinine > 2.5 mg/dl:

YES  NO  UNK

Chronic Dialysis:

YES  NO  UNK

Renal Tx since Thoracic Tx:

YES  NO  UNK

Stroke:

YES  NO  UNK

Drug Treated Hyperlipidemia:

YES  NO  UNK

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)

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 Positive

Culture:

 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

Positive

- RIBA:
- Negative
  - Not Done
  - UNK/Cannot Disclose
  - Positive
- HCV RNA:
- 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

**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

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:

Other therapies:  YES  NO

Photopheresis

If Yes, check all that apply:

Plasmapheresis

Total Lymphoid Irradiation (TLI)

### 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"/>

### 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"/>

