

# VCA - uterus transplant recipient follow-up



OMB No. 0915-0157, Expiration date: 9/30/2026

The transplant recipient follow-up (TRF) forms are generated at six months, one year and annually thereafter following transplantation, until either graft failure, recipient death or lost to follow-up is reported. Forms are generated by the age at transplant, not the age at listing. The TRF record is completed by the transplant hospital responsible for follow-up of the recipient.

Complete the TRF with only the applicable patient information since the last follow-up period. It is not to contain information pertaining solely to the previous or next follow-up period. For example: the 6-month follow-up should contain information from the time after the TRR was completed to the 6-month transplant anniversary date; the 1-year follow-up should contain information from the day after the 6-month transplant anniversary date to the 1-year transplant anniversary date; the 2-year follow-up should contain information from the day after the 1-year transplant anniversary date to the 2-year anniversary date.

Complete one TRF form for recipients of bilateral upper limbs. Complete separate TRF forms for each VCA organ transplant.

The TRF must be validated within 90 days of the record generation date. See OPTN Policies (<https://optn.transplant.hrsa.gov/policies-bylaws/policies>) for additional information.

## Recipient information

Question	Answers
TRF form type (prepopulated)*	_____
Recipient first name (prepopulated)*	_____
Recipient last name (prepopulated)*	_____
Recipient middle initial (prepopulated)	_____
Date of birth (prepopulated)*	_____
SSN (prepopulated)*	_____
Birth sex (prepopulated)*	_____
HIC (prepopulated)	_____
Transplant date (prepopulated)*	_____
State of permanent residence*	_____
Permanent ZIP code	_____
Expected date (prepopulated)*	_____

## Provider information

Question	Answers
Treating reconstructive surgeon name*	_____
Treating reconstructive surgeon NPI #*	_____
Treating transplant physician name*	_____
Treating transplant physician NPI #*	_____
Follow-up care provided by*	_____
Other, specify	_____

## Donor information

Question	Answers
UNOS donor ID # (prepopulated)*	_____
Donor type (prepopulated)*	_____

OPO (prepopulated)

\_\_\_\_\_

## Patient status

### Question

### Answers

Date last seen, graft removed, or death\*

\_\_\_\_\_

Patient status\*

\_\_\_\_\_

*If patient status is "Dead", select the patient's cause of death*

Primary cause of death

\_\_\_\_\_

Other, specify

\_\_\_\_\_

Has patient been hospitalized since the last patient status date\*

\_\_\_\_\_

Number of hospitalizations (1-100)

\_\_\_\_\_

## Socio-demographic information

### Question

### Answers

*For recipients 18 years of age or older*

Working for income

\_\_\_\_\_

## Socio-demographic information - Source of payment

### Question

### Answers

Grant funding\*

\_\_\_\_\_

Institutional funding\*

\_\_\_\_\_

Primary source of payment\*

\_\_\_\_\_

*If primary source of payment is "Foreign government, specify" select foreign government*

Primary source of payment - foreign government, specify

\_\_\_\_\_

## Functional status

### Question

### Answers

*For recipients younger than 18 years of age at transplant and younger than 26 years of age at follow-up*

Motor development

\_\_\_\_\_

Psychosocial consult performed\*

\_\_\_\_\_

## Functional status: SF-12 score - Physical health

Question	Answers
Physical functioning (PF) score (0.0-100.0)	_____
Role-physical (RP) score (0.0-100.0)	_____
Bodily pain (BP) score (0.0-100.0)	_____
General health (GH) score (0.0-100.0)	_____
Physical component summary (PCS) score (0.0-100.0)	_____

## Functional status: SF-12 score - Mental health

Question	Answers
Vitality (VT) score (0.0-100.0)	_____
Social functioning (SF) score (0.0-100.0)	_____
Role-emotional (RE) score (0.0-100.0)	_____
Mental health (MH) score (0.0-100.0)	_____
Mental component summary (MCS) score (0.0-100.0)	_____

## Functional status: Uterus

Question	Answers
Number of embryo transfers during this follow-up period (0-10)*	_____
<i>Enter transfer date or reason why there is no transfer date for each embryo transfer</i>	
Embryo transfer date #1	_____
Reason if no embryo transfer date	_____
Embryo transfer date #2	_____
Reason if no embryo transfer date	_____
Embryo transfer date #3	_____
Reason if no embryo transfer date	_____
Embryo transfer date #4	_____
Reason if no embryo transfer date	_____
Embryo transfer date #5	_____
Reason if no embryo transfer date	_____
Embryo transfer date #6	_____
Reason if no embryo transfer date	_____
Embryo transfer date #7	_____
Reason if no embryo transfer date	_____
Embryo transfer date #8	_____
Reason if no embryo transfer date	_____

Embryo transfer date #9	_____
Reason if no embryo transfer date	_____
Embryo transfer date #10	_____
Reason if no embryo transfer date	_____
Number of pregnancies post-transplant of uterus during this follow-up period (which may or may not have resulted in a live birth: 0-3)	_____
<i>Enter for each pregnancy</i>	
Date of positive pregnancy test result post-transplant	_____
Reason if no date of positive pregnancy test result	_____
Date embryonic heartbeat first detected by ultrasound	_____
Reason if no date of embryonic heartbeat first detected by ultrasound	_____
Estimated delivery date	_____
Reason if no estimated delivery date	_____
Pregnancy complications	_____
If yes, specify	_____
Did pregnancy result in a miscarriage?	_____
If yes, date of miscarriage	_____
Date of admission to transplant center for delivery	_____
Reason if no date of admission to transplant center for delivery	_____
Delivery type	_____
Delivery date	_____
Maternal complications at delivery	_____
If yes, specify	_____
Blood transfusions required following delivery	_____
Date of discharge from transplant center post-delivery	_____
Reason if no date of discharge from transplant center post-delivery	_____
Post-delivery complications	_____
If yes, specify	_____
Subsequent surgeries since delivery	_____
<i>Enter for each subsequent surgery</i>	
Surgical procedure	_____
Surgical date	_____
<i>Enter for each subsequent surgery</i>	

Surgical procedure

\_\_\_\_\_

Surgical date

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_

Surgical date

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_

Surgical date

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_

Surgical date

\_\_\_\_\_

*[Please submit additional subsequent surgeries on a separate attachment]*

*Enter for each pregnancy*

Date of positive pregnancy test result post-transplant

\_\_\_\_\_

Reason if no date of positive pregnancy test result

\_\_\_\_\_

Date embryonic heartbeat first detected by ultrasound

\_\_\_\_\_

Reason if no date of embryonic heartbeat first detected by ultrasound

\_\_\_\_\_

Estimated delivery date

\_\_\_\_\_

Reason if no estimated delivery date

\_\_\_\_\_

Pregnancy complications

\_\_\_\_\_

If yes, specify

\_\_\_\_\_

Did pregnancy result in a miscarriage?

\_\_\_\_\_

If yes, date of miscarriage

\_\_\_\_\_

Date of admission to transplant center for delivery

\_\_\_\_\_

Reason if no date of admission to transplant center for delivery

\_\_\_\_\_

Delivery type

\_\_\_\_\_

Delivery date

\_\_\_\_\_

Maternal complications at delivery

\_\_\_\_\_

If yes, specify

\_\_\_\_\_

Blood transfusions required following delivery

\_\_\_\_\_

Date of discharge from transplant center post-delivery	_____
Reason if no date of discharge from transplant center post-delivery	_____
Post-delivery complications	_____
If yes, specify	_____
Subsequent surgeries since delivery	_____
<i>Enter for each subsequent surgery</i>	
Surgical procedure	_____
Surgical date	_____
<i>Enter for each subsequent surgery</i>	
Surgical procedure	_____
Surgical date	_____
<i>Enter for each subsequent surgery</i>	
Surgical procedure	_____
Surgical date	_____
<i>Enter for each subsequent surgery</i>	
Surgical procedure	_____
Surgical date	_____
<i>Enter for each subsequent surgery</i>	
Surgical procedure	_____
Surgical date	_____
<i>Enter for each subsequent surgery</i>	
Surgical procedure	_____
Surgical date	_____
<i>[Please submit additional subsequent surgeries on a separate attachment]</i>	
<i>Enter for each pregnancy</i>	
Date of positive pregnancy test result post-transplant	_____
Reason if no date of positive pregnancy test result	_____
Date embryonic heartbeat first detected by ultrasound	_____
Reason if no date of embryonic heartbeat first detected by ultrasound	_____
Estimated delivery date	_____
Reason if no estimated delivery date	_____
Pregnancy complications	_____

If yes, specify

\_\_\_\_\_ /

Did pregnancy result in a miscarriage?

\_\_\_\_\_

If yes, date of miscarriage

\_\_\_\_\_

Date of admission to transplant center for delivery

\_\_\_\_\_

Reason if no date of admission to transplant center for delivery

\_\_\_\_\_

Delivery type

\_\_\_\_\_

Delivery date

\_\_\_\_\_

Maternal complications at delivery

\_\_\_\_\_

If yes, specify

\_\_\_\_\_ /

Blood transfusions required following delivery

\_\_\_\_\_

Date of discharge from transplant center post-delivery

\_\_\_\_\_

Reason if no date of discharge from transplant center post-delivery

\_\_\_\_\_

Post-delivery complications

\_\_\_\_\_

If yes, specify

\_\_\_\_\_ /

Subsequent surgeries since delivery

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_ /

Surgical date

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_ /

Surgical date

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_ /

Surgical date

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_ /

Surgical date

\_\_\_\_\_

*Enter for each subsequent surgery*

Surgical procedure

\_\_\_\_\_

Surgical date

\_\_\_\_\_

*[Please submit additional subsequent surgeries on a separate attachment]*

Readmitted to the hospital\*

\_\_\_\_\_

*Enter for each readmission*

If yes, reason for readmission

\_\_\_\_\_

If yes, readmission date

\_\_\_\_\_

*Enter for each readmission*

If yes, reason for readmission

\_\_\_\_\_

If yes, readmission date

\_\_\_\_\_

*Enter for each readmission*

If yes, reason for readmission

\_\_\_\_\_

If yes, readmission date

\_\_\_\_\_

*Enter for each readmission*

If yes, reason for readmission

\_\_\_\_\_

If yes, readmission date

\_\_\_\_\_

*Enter for each readmission*

If yes, reason for readmission

\_\_\_\_\_

If yes, readmission date

\_\_\_\_\_

*[Please submit additional readmissions on a separate attachment]*

Hysterectomy performed following successful delivery or due to complication\*

\_\_\_\_\_

If yes, hysterectomy date

\_\_\_\_\_

If yes, then specify reason

\_\_\_\_\_

Other, specify

\_\_\_\_\_

Surgical, medical, or psychiatric complications after hysterectomy\*

\_\_\_\_\_

*Enter for each complication*



Complication	<hr/>
Date of complication	<hr/>
<i>Enter for each complication</i>	
Complication	<hr/>
Date of complication	<hr/>
<i>Enter for each complication</i>	
Complication	<hr/>
Date of complication	<hr/>
<i>Enter for each complication</i>	
Complication	<hr/>
Date of complication	<hr/>
<i>Enter for each complication</i>	
Complication	<hr/>
Date of complication	<hr/>
<i>Enter for each complication</i>	
Complication	<hr/>
Date of complication	<hr/>
<i>[Please submit additional complications on a separate attachment]</i>	
New onset diagnosed psychiatric condition(s)*	<hr/>
If yes, specify	<hr/>
Visual changes noted on cervical examination*	<hr/>
If yes, specify	<hr/>

### Clinical information

Question	Answers
<i>Enter height or height status</i>	
Height (cm: 1.00-225.00)	<hr/>
Height status	<hr/>
<i>Enter weight or weight status</i>	
Weight (kg: 0.45-294.84)*	<hr/>
Weight status	<hr/>

## Clinical information: Noncompliance

Question	Answers
Immunosuppression*	_____
Rehabilitation*	_____
Level of activity*	_____
Other*	_____
Other, specify	_____

## Clinical information: Post-transplant

Question	Answers
Graft status*	_____
<i>If "Planned removal"</i>	
Date of removal	_____
<i>If "Failed"</i>	
Date of graft failure	_____
<i>Causes of graft failure</i>	
Acute rejection	_____
Acute rejection - Banff score	_____
Chronic rejection	_____
Chronic rejection - visual skin changes	_____
Vascular complications	_____
Sepsis / infection	_____
Trauma	_____
Patient requested removal	_____
Non-adherence	_____
Other	_____
Other, specify	_____
Did patient have any acute rejection episodes during the follow-up period	_____
If yes, number of episodes (1-100)	_____
<i>Enter for each episode</i>	
Date of acute rejection diagnosis	_____
Acute rejection was treated	_____
Visual skin changes	_____
Biopsy was done to confirm acute rejection	_____
Banff score	_____
<i>Enter for each episode</i>	

Date of acute rejection diagnosis	_____
Acute rejection was treated	_____
Visual skin changes	_____
Biopsy was done to confirm acute rejection	_____
Banff score	_____
<i>Enter for each episode</i>	
Date of acute rejection diagnosis	_____
Acute rejection was treated	_____
Visual skin changes	_____
Biopsy was done to confirm acute rejection	_____
Banff score	_____
<i>Enter for each episode</i>	
Date of acute rejection diagnosis	_____
Acute rejection was treated	_____
Visual skin changes	_____
Biopsy was done to confirm acute rejection	_____
Banff score	_____
<i>Enter for each episode</i>	
Date of acute rejection diagnosis	_____
Acute rejection was treated	_____
Visual skin changes	_____
Biopsy was done to confirm acute rejection	_____
Banff score	_____

## Clinical information: Most recent lab data

Question	Answers
<i>Enter serum creatinine or serum creatinine status</i>	
Serum creatinine (mg/dL: 0.10-25.00)	_____
Serum creatinine status	_____
<i>Enter hemoglobin A1c or hemoglobin A1c status</i>	
Hemoglobin A1c (%: 0-100)	_____
Hemoglobin A1c status	_____
Donor specific antibodies (DSA)*	_____

## Clinical information: Complications

Question	Answers
New onset diabetes*	_____
Metabolic complications*	_____
Infectious complications*	_____

Other complications\*

Other, specify

\_\_\_\_\_

\_\_\_\_\_

## Post-transplant malignancy

Question

Answers

Post-transplant malignancy\*

\_\_\_\_\_

## Post-transplant malignancy: Donor related

Question

Answers

*If post-transplant malignancy is yes*

Donor related

\_\_\_\_\_

*If yes, select one or more tumor types and diagnosis date for each*

Skin: Squamous cell

Yes

Skin: Squamous cell - Diagnosis date

\_\_\_\_\_

Skin: Basal cell

Yes

Skin: Basal cell - Diagnosis date

\_\_\_\_\_

Skin: Melanoma

Yes

Skin: Melanoma - Diagnosis date

\_\_\_\_\_

Kaposi's sarcoma: Cutaneous

Yes

Kaposi's sarcoma: Cutaneous - Diagnosis date

\_\_\_\_\_

Kaposi's sarcoma: Visceral

Yes

Kaposi's sarcoma: Visceral - Diagnosis date

\_\_\_\_\_

Brain

\_\_\_\_\_

Brain - Other, specify

\_\_\_\_\_

Brain - Diagnosis date

\_\_\_\_\_

Renal carcinoma

Yes

Renal carcinoma - Diagnosis date

\_\_\_\_\_

Carcinoma of vulva, perineum or penis, scrotum

Yes

Carcinoma of vulva, perineum or penis, scrotum - Diagnosis date

\_\_\_\_\_

Carcinoma of the uterus

Yes

Carcinoma of the uterus - Diagnosis date

\_\_\_\_\_

Ovarian

Yes

Ovarian - Diagnosis date

\_\_\_\_\_

Testicular	<input type="checkbox"/> Yes
Testicular - Diagnosis date	_____
Esophagus	<input type="checkbox"/> Yes
Esophagus - Diagnosis date	_____
Stomach	<input type="checkbox"/> Yes
Stomach - Diagnosis date	_____
Small intestine	<input type="checkbox"/> Yes
Small intestine - Diagnosis date	_____
Pancreas	<input type="checkbox"/> Yes
Pancreas - Diagnosis date	_____
Larynx	<input type="checkbox"/> Yes
Larynx - Diagnosis date	_____
Tongue, throat	<input type="checkbox"/> Yes
Tongue, throat - Diagnosis date	_____
Thyroid	<input type="checkbox"/> Yes
Thyroid - Diagnosis date	_____
Bladder	<input type="checkbox"/> Yes
Bladder - Diagnosis date	_____
Breast	<input type="checkbox"/> Yes
Breast - Diagnosis date	_____
Prostate	<input type="checkbox"/> Yes
Prostate - Diagnosis date	_____
Colo-rectal	<input type="checkbox"/> Yes
Colo-rectal - Diagnosis date	_____
Primary hepatic tumor	<input type="checkbox"/> Yes
Primary hepatic tumor - Diagnosis date	_____
Metastatic liver tumor	<input type="checkbox"/> Yes
Metastatic liver tumor - Diagnosis date	_____
Lung	<input type="checkbox"/> Yes
Lung - Diagnosis date	_____
Leukemia	<input type="checkbox"/> Yes
Leukemia - Diagnosis date	_____
Sarcomas (excluding Kaposi's)	<input type="checkbox"/> Yes
Sarcomas (excluding Kaposi's) - Diagnosis date	_____
Other cancers	<input type="checkbox"/> Yes

Other cancers - Specify	_____
Other cancers - Diagnosis date	_____
Primary unknown	<input type="checkbox"/> Yes
Primary unknown - Diagnosis date	_____

## Post-transplant malignancy: Recurrence of pretransplant malignancy

Question	Answers
<i>If post-transplant malignancy is yes</i>	
Recurrence of pre-transplant malignancy	_____
<i>If yes, type of pre-existing tumor</i>	
Type of pre-existing tumor	_____
If other cancer, specify	_____
Date of recurrence (post-transplant)	_____

## Post-transplant malignancy: Post-transplant de novo solid tumor

Question	Answers
<i>If post-transplant malignancy is yes</i>	
De novo tumor	_____
<i>If yes, select one or more tumor types and diagnosis date for each</i>	
Skin: Squamous cell	<input type="checkbox"/> Yes
Skin: Squamous cell - Diagnosis date	_____
Skin: Basal cell	<input type="checkbox"/> Yes
Skin: Basal cell - Diagnosis date	_____
Skin: Melanoma	<input type="checkbox"/> Yes
Skin: Melanoma - Diagnosis date	_____
Kaposi's sarcoma: Cutaneous	<input type="checkbox"/> Yes
Kaposi's sarcoma: Cutaneous - Diagnosis date	_____
Kaposi's sarcoma: Visceral	<input type="checkbox"/> Yes
Kaposi's sarcoma: Visceral - Diagnosis date	_____
Brain	_____
Brain - Other, specify	_____
Brain - Diagnosis date	_____
Renal carcinoma	<input type="checkbox"/> Yes
Renal carcinoma - Diagnosis date	_____
Carcinoma of vulva, perineum or penis, scrotum	<input type="checkbox"/> Yes
Carcinoma of vulva, perineum or penis, scrotum - Diagnosis date	_____

Carcinoma of the uterus	<input type="checkbox"/> Yes
Carcinoma of the uterus - Diagnosis date	_____
Ovarian	<input type="checkbox"/> Yes
Ovarian - Diagnosis date	_____
Testicular	<input type="checkbox"/> Yes
Testicular - Diagnosis date	_____
Esophagus	<input type="checkbox"/> Yes
Esophagus - Diagnosis date	_____
Stomach	<input type="checkbox"/> Yes
Stomach - Diagnosis date	_____
Small intestine	<input type="checkbox"/> Yes
Small intestine - Diagnosis date	_____
Pancreas	<input type="checkbox"/> Yes
Pancreas - Diagnosis date	_____
Larynx	<input type="checkbox"/> Yes
Larynx - Diagnosis date	_____
Tongue, throat	<input type="checkbox"/> Yes
Tongue, throat - Diagnosis date	_____
Thyroid	<input type="checkbox"/> Yes
Thyroid - Diagnosis date	_____
Bladder	<input type="checkbox"/> Yes
Bladder - Diagnosis date	_____
Breast	<input type="checkbox"/> Yes
Breast - Diagnosis date	_____
Prostate	<input type="checkbox"/> Yes
Prostate - Diagnosis date	_____
Colo-rectal	<input type="checkbox"/> Yes
Colo-rectal - Diagnosis date	_____
Primary hepatic tumor	<input type="checkbox"/> Yes
Primary hepatic tumor - Diagnosis date	_____
Metastatic liver tumor	<input type="checkbox"/> Yes
Metastatic liver tumor - Diagnosis date	_____
Lung	<input type="checkbox"/> Yes
Lung - Diagnosis date	_____
Leukemia	<input type="checkbox"/> Yes

Leukemia - Diagnosis date	_____
Sarcomas (excluding Kaposi's)	<input type="checkbox"/> Yes
Sarcomas (excluding Kaposi's) - Diagnosis date	_____
Other cancers	<input type="checkbox"/> Yes
Other cancers - Specify	_____
Other cancers - Diagnosis date	_____
Primary unknown	<input type="checkbox"/> Yes
Primary unknown - Diagnosis date	_____

## Post-transplant malignancy: Post-transplant lymphoproliferative disease and lymphoma

Question	Answers
<i>If post-transplant malignancy is yes</i>	
Post-transplant lymphoproliferative disease (PTLD) and Lymphoma	_____
Diagnosis date	_____
Pathology	_____
Other, specify	_____

## Treatment

Question	Answers
Antiviral*	_____
Antibiotic*	_____
Antifungal*	_____

## Non-topical immunosuppressive medication - Drug used for induction, acute rejection, or maintenance

Question	Answers
Steroids (prednisone, methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance <input type="checkbox"/> Anti-rejection indication

## Non-topical immunosuppressive medication - Drugs used for acute rejection

Question	Answers
Atgam	<input type="checkbox"/> Anti-rejection indication
Campath (alemtuzumab, anti-CD52)	<input type="checkbox"/> Anti-rejection indication



Cytosan (cyclophosphamide)	<input type="checkbox"/> Anti-rejection indication
Methotrexate (Folex PFS, Mexate-AQ, Rheumatrex)	<input type="checkbox"/> Anti-rejection indication
OKT3 (Orthoclone, muromonab)	<input type="checkbox"/> Anti-rejection indication
Rituxan (rituximab)	<input type="checkbox"/> Anti-rejection indication
Simulect (basiliximab)	<input type="checkbox"/> Anti-rejection indication
Thymoglobulin	<input type="checkbox"/> Anti-rejection indication

## Non-topical immunosuppressive medication - Drug used for previous maintenance or current maintenance

Question	Answers
<i>Cyclosporine, select from the following:</i>	
EON (generic cyclosporine)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Gengraf (Abbott cyclosporine)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Neoral (CyA-NOF)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Other generic cyclosporine, specify brand	_____
Other generic cyclosporine	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Sandimmune (cyclosporine A)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Imuran (azathioprine, AZA)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Leflunomide (LFL)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
<i>Mycophenolate acid, select from the following:</i>	
CellCept (MMF)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Generic MMF (generic CellCept)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Myfortic (mycophenolate acid)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Nulojix (belatacept)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Rapamune (sirolimus, Rapamycin)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
<i>Tacrolimus, select from the following:</i>	
Astagraf XL (extended release tacrolimus)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance

Generic tacrolimus (generic Prograf)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Prograf (FK506)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
Zortress (everolimus)	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance
<b>Other drugs</b>	
Other immunosuppressive medication 1, specify: _____	
Other immunosuppressive medication 1	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance <input type="checkbox"/> Anti-rejection indication
Other immunosuppressive medication 2, specify: _____	
Other immunosuppressive medication 2	<input type="checkbox"/> Previous maintenance <input type="checkbox"/> Current maintenance <input type="checkbox"/> Anti-rejection indication

## Public Burden/Privacy Act Statements

Department of Health and Human Services  
Health Resources and Services Administration

OMB No: 0915-0157  
Expiration Date: 9/30/2026

# ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK (OPTN)

## DATA COLLECTION

**DATA ACCURACY CERTIFICATION:** I certify that the data entered by me in UNet<sup>SM</sup> are accurate, timely, and complete to the best of my knowledge, information and belief. These data are based upon information contained in corresponding medical records and other source documents, or where appropriate, are based upon clinical observation.

**PUBLIC BURDEN STATEMENT:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0157. Public reporting burden for the applicant for this collection of information is estimated to average 53 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 1033, Rockville, Maryland 20857.

**PRIVACY ACT STATEMENT:** In accordance with the requirements of the Privacy Act of 1974 (<https://www.federalregister.gov/documents/2022/08/01/2022-16344/privacy-act-of-1974-system-of-records>) as amended, 42 U.S.C. § 273, et seq., and 42 CRF Part 121 authorize collection of this information by the OPTN. This information is distributed to the Scientific Registry of Transplant Recipients (SRTR) and the Health Resources and Services Administration (HRSA), with the United States Department of Health and Human Services. The primary uses of this information are to match organ donors with recipients, to monitor compliance of member organizations with OPTN requirements, to review and report on the status of organ donation and transplantation in the United States, and to provide data to researchers and government agencies to study transplantation. The routine uses which may be made of this information are: (i) to organ procurement organizations and transplant hospitals to match organ donors with compatible recipients and validate the accuracy of donor and recipient; (ii) to the Department of Justice to use in defending litigation; (iii) to a congressional office upon the request of an individual concerning records pertaining to him/her; (iv) for research purposes, if certain requirements are satisfied and data use agreements are executed; and (v) to Agency contractors who have been engaged by the Agency to assist in accomplishment of an Agency function relating to the purposes of this system and who need to have access to the records in order to assist the Agency. Furnishing the remaining information requested is required by law of organ procurement organizations and transplant hospitals and the failure to submit such information may result in enforcement actions resulting from noncompliance with OPTN requirements.  
HRSA (08/02)

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