

**Records** ?

**Intestine 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 style="width: 100%;" type="text"/>
State of Permanent Residence:	<input style="width: 100%;" type="text"/>
Zip Code:	<input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>

Provider Information	
Recipient Center:	
Followup Center:	
Physician Name:	<input style="width: 100%;" type="text"/>
UPIN#:	<input style="width: 100%;" 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 style="width: 100%;" type="text"/>

Donor Information	
UNOS Donor ID #:	
Donor Type:	

Patient Status	
Date: Last Seen, Retransplanted or Death *	<input style="width: 100%;" type="text"/>
Patient Status: *	<input type="radio"/> LIVING <input type="radio"/> DEAD <input type="radio"/> RETRANSPLANTED
Primary Cause of Death:	<input style="width: 100%;" type="text"/>
Specify:	<input style="width: 100%;" type="text"/>
Contributory Cause of Death:	<input style="width: 100%;" type="text"/>
Specify:	<input style="width: 100%;" type="text"/>
Contributory Cause of Death:	<input style="width: 100%;" type="text"/>
Specify:	<input style="width: 100%;" type="text"/>
Hospitalizations:	
Has the patient been hospitalized since the last patient status date:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Number of Hospitalizations:	<input style="width: 20%;" type="text"/> St= <input style="width: 20%;" type="text"/>
Noncompliance:	
Was there evidence of noncompliance with immunosuppression medication during this follow-up period that compromised the patient's recovery:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK

**Functional Status:**

- Performs activities of daily living with NO assistance.
- Performs activities of daily living with SOME assistance.
- Performs activities of daily living with TOTAL assistance.
- Not Applicable (example: Patient hospitalized, < 1 year old)
- Unknown

**Physical Capacity:**

- No Limitations
- Limited Mobility
- Wheelchair bound or more limited
- Not Applicable (example: < 1 year old)
- Unknown

**Working for income:**

YES  NO  UNK

**If No, Not Working Due To:**

- Disability
- Demands of Treatment
- Insurance Conflict
- Inability to Find Work
- Patient Choice - Homemaker
- Patient Choice - Student Full Time/Part Time
- Patient Choice - Retired
- Patient Choice - Other
- Unknown

**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
- 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

**TPN Dependent:**  YES  NO  
**IV Dependent:**  YES  NO  
**Oral Feeding:**  YES  NO  
**Tube Feeding:**  YES  NO  
**Date of Failure:**   
**Primary Cause of Failure:**  RECURRENT TUMOR  
 ACUTE REJECTION  
 CHRONIC REJECTION  
 TECHNICAL PROBLEMS  
 INFECTION  
 LYMPHOPROLIFERATIVE DISEASE  
 PATIENT NONCOMPLIANCE  
 OTHER SPECIFY  
**Other, Specify:**

**Diabetes during the follow-up period:**  YES  NO  UNK  
 Insulin dependent:  YES  NO  UNK

**Most Recent Lab date:**   
**Total Bilirubin:**  mg/dl **St=**   
**Serum Albumin:**  mg/dl **St=**   
**Serum Creatinine:**  mg/dl **St=**

**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  
**Was biopsy done to confirm acute rejection:**  Biopsy not done  
 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):	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Antibody:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
RNA:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose

**CMV**  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 <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
IgM:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
Nucleic Acid Testing:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
Culture:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose

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HBV	
Test	Result
Was there clinical disease:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Liver Histology:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
Core Antibody:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
Surface Antigen:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
HBV DNA:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose

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HCV	
Test	Result
Was there clinical disease:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Liver Histology:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose

Antibody:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
RIBA:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
HCV RNA:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose

<b>EBV</b>	<input type="radio"/> YES <input type="radio"/> NO
<b>Test</b>	<b>Result</b>
Was there clinical disease:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
IgG:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
IgM:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
EBV DNA:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose

<b>Postransplant Malignancy:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>Donor Related:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>Recurrence of Pre-Tx Tumor:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>De Novo Solid Tumor:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>De Novo Lymphoproliferative disease and Lymphoma:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK

**Treatment**

<b>Biological or Anti-viral therapy:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown/Cannot disclose
If Yes, check all that apply:	<input type="checkbox"/> Acyclovir (Zovirax) <input type="checkbox"/> Cytogamn (CMV) <input type="checkbox"/> Gamimune <input type="checkbox"/> Gammagard <input type="checkbox"/> Ganciclovir (Cytovene) <input type="checkbox"/> Valgancyclovir (Valcyte) <input type="checkbox"/> HBIG (Hepatitis B Immune Globulin) <input type="checkbox"/> Flu Vaccine (Influenza Virus) <input type="checkbox"/> Lamivudine (Epivir) (for treatment of Hepatitis B) <input type="checkbox"/> 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 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 with the intention to maintain them long-term (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.**

	Prev Maint	Curr Maint	AR
Steroids (Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atgam (ATG, Anti-thymocyte Globulin)/NRATG/NRATS	<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"/>

**Other Immunosuppressive Medications**

		Prev Maint	Curr Maint	AR
Campath - Alemtuzumab (anti-CD52)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclophosphamide (Cytoxan)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leflunomide (LFL)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)		<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"/>
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"/>
ERL (Myfortic) - Mycophenolate Sodium		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
FTY 720		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

UNOS View Only	
Comments:	<input type="text"/>