

Records ?

Intestine 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:	
Surgeon Name:	<input type="text"/>
UPIN#:	<input type="text"/>
Donor Information	
UNOS Donor ID #:	
Donor Type:	
Patient Status	
Primary Diagnosis:	<input type="text"/>
Specify:	<input type="text"/>
Secondary 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:	<input type="text"/>
Date of Discharge from Tx Center:	<input type="text"/>
Was patient hospitalized during the last 90 days prior to the transplant admission:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Medical Condition at time of transplant:	<input type="radio"/> IN INTENSIVE CARE UNIT <input type="radio"/> HOSPITALIZED NOT IN ICU <input type="radio"/> NOT HOSPITALIZED
Patient on Life Support:	<input type="radio"/> YES <input type="radio"/> NO <input type="checkbox"/> Ventilator <input type="checkbox"/> Artificial Liver

Specify:	<input type="checkbox"/> Other Mechanism, Specify <input style="width: 150px; height: 15px;" type="text"/>
Functional Status:	<input type="radio"/> Performs activities of daily living with NO assistance. <input type="radio"/> Performs activities of daily living with SOME assistance. <input type="radio"/> Performs activities of daily living with TOTAL assistance. <input type="radio"/> Not Applicable (example: Patient hospitalized, < 1 year old) <input type="radio"/> Unknown
Physical Capacity:	<input type="radio"/> No Limitations <input type="radio"/> Limited Mobility <input type="radio"/> Wheelchair bound or more limited <input type="radio"/> Not Applicable (example: < 1 year old) <input type="radio"/> Unknown
Working for income:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK <input type="radio"/> Disability <input type="radio"/> Demands of Treatment <input type="radio"/> Insurance Conflict <input type="radio"/> Inability to Find Work
If No, Not Working Due To:	<input type="radio"/> Patient Choice - Homemaker <input type="radio"/> Patient Choice - Student Full Time/Part Time <input type="radio"/> Patient Choice - Retired <input type="radio"/> Patient Choice - Other <input type="radio"/> Unknown
If Yes:	<input type="radio"/> Working Full Time <input type="radio"/> Working Part Time due to Demands of Treatment <input type="radio"/> Working Part Time due to Disability <input type="radio"/> Working Part Time due to Insurance Conflict <input type="radio"/> Working Part Time due to Inability to Find Full Time Work <input type="radio"/> Working Part Time due to Patient Choice <input type="radio"/> Working Part Time Reason Unknown <input type="radio"/> Working, Part Time vs. Full Time Unknown
Academic Progress:	<input type="radio"/> Within One Grade Level of Peers <input type="radio"/> Delayed Grade Level <input type="radio"/> Special Education <input type="radio"/> Not Applicable < 5 years old <input type="radio"/> Status Unknown
Academic Activity Level:	<input type="radio"/> Full academic load <input type="radio"/> Reduced academic load <input type="radio"/> Unable to participate in academics due to disease or condition <input type="radio"/> Not Applicable < 5 years old <input type="radio"/> Status Unknown
Source of Payment:	Primary: <input style="width: 100px;" type="text"/> Specify: <input style="width: 100px;" type="text"/> Secondary: <input style="width: 100px;" type="text"/>

Clinical Information : PRETRANSPLANT	
Height:	%ile

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

HCV: YES NO

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

EBV: 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
	<input type="radio"/> Positive <input type="radio"/> Negative

EBV DNA: Not Done
 UNK/Cannot Disclose

Total Bilirubin: mg/dl ST=

Serum Albumin: g/dl ST=

Serum Creatinine: mg/dl ST=

Malignancies between listing and transplant: YES NO UNK

If yes, specify type:

Skin Melanoma
 Skin Non-Melanoma
 CNS Tumor
 Genitourinary
 Breast
 Thyroid
 Tongue/Throat/Larynx
 Lung
 Leukemia/Lymphoma
 Type Unknown
 Other, specify

Specify:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Procedure Information:

Intestine Only Venous Drainage: Portal Systemic

Native Viscera Venous Drainage: Portal Systemic

Procedure Type:

Whole Intestine
 Intestine Segment
 Whole Intestine with Pancreas (Technical Reasons)
 Intestine Segment with Pancreas (Technical Reasons)

Organ Type:

Stomach
 Small Intestine
 Duodenum
 Large Intestine

Preservation Information:

Total Ischemic Time (include cold, warm and anastomotic time): hrs ST=

Risk Factors:

Recent Septicemia: YES NO UNK

Exhausted Vascular Access: YES NO UNK

Liver Dysfunction: YES NO UNK

Previous Abdominal Surgery: YES NO UNK

Number Previous Abdominal Surgeries: ST=

Dilated/Non-Functional Bowel Segments: YES NO UNK

Other:

Clinical Information : POST TRANSPLANT

Graft Status: Functioning Failed

TPN Dependent: YES NO
IV Dependent: YES NO
Oral Feeding: YES NO
Tube Feed: YES NO
Date of Graft Failure:
 RECURRENT TUMOR
 ACUTE REJECTION
 CHRONIC REJECTION
Primary Cause of Graft Failure: TECHNICAL PROBLEMS
 INFECTION
 LYMPHOPROLIFERATIVE DISEASE
 OTHER SPECIFY
Specify:

Yes, at least one episode treated with anti-rejection agent
Did patient have any acute rejection episodes between transplant and discharge: 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)
 Cytogamn (CMV)
 Gamimune
 Gammagard
 Ganciclovir (Cytovene)
 Valgancyclovir (Valcyte)
 HBIG (Hepatitis B Immune Globulin)
 Flu Vaccine (Influenza Virus)
 Lamivudine (Epiriv) (for treatment of Hepatitis B)
 Other, Specify
If Yes, check all that apply:
Specify:
Specify:

Other therapies: YES NO
 Photopheresis
 Plasmapheresis
 Total Lymphoid Irradiation (TLI)
If Yes, check all that apply:

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 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, 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.

Current Maintenance (Curr Maint) includes all immunosuppressive medications given at the current clinic visit to begin in the next report period 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atgam (ATG, Anti-thymocyte Globulin)/NRATG/NRATS	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
OKT3 (Orthoclone, Muromonab)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Thymoglobulin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Simulect - Basiliximab	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Zenapax - Daclizumab	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Azathioprine (AZA, Imuran)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
EON (Generic Cyclosporine)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Gengraf (Abbott Cyclosporine)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other generic Cyclosporine, specify brand: <input type="text"/>	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Neoral (CyA-NOF)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sandimmune (Cyclosporine A)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mycophenolate Mofetil (MMF, Cellcept, RS61443)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tacrolimus (Prograf, FK506)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sirolimus (RAPA, Rapamycin, Rapamune)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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 (Cytoxan)	<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"/>
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"/>
ERL (Myfortic) - Mycophenolate Sodium	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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UNOS View Only

Comments: