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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"/>
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
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:

- 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

Source of Payment:

Primary:

Specify:

Secondary:

Clinical Information : PRETRANSPLANT		
Previous Transplants:		
Previous Transplant Organ	Previous Transplant Date	Previous Transplant Graft Fail Date
<i>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.</i>		
Pretransplant Dialysis: <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
If Yes, Date First Dialyzed:	<input type="text"/>	ST= <input type="text"/>
Serum Creatinine at Time of Tx:	<input type="text"/> mg/dl	ST= <input type="text"/>
Viral Detection		
Have any of the following viruses ever been tested for:		

(HIV, CMV, HBV, HCV, EBV)		<input type="radio"/> YES <input type="radio"/> NO
HIV:		<input type="radio"/> YES <input type="radio"/> 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:		<input type="radio"/> YES <input type="radio"/> 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	
HBV:		<input type="radio"/> YES <input type="radio"/> 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	
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	

UNK/Cannot Disclose

HBV DNA: Positive
 Negative
 Not Done
 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
EBV DNA:	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose

Was preimplantation kidney biopsy performed at the transplant center: YES NO

Did patient receive any pretransplant blood transfusions: YES NO UNK

Any tolerance induction technique used: 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

Skin Melanoma

Skin Non-Melanoma

CNS Tumor

Genitourinary

Breast

Thyroid

Tongue/Throat/Larynx

Lung

Leukemia/Lymphoma

Type Unknown

Other, specify

If yes, specify type:

Specify:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Procedure Type:

Kidney Preservation Information:

Total Cold ischemia Time: (if pumped, include pump time) hrs **ST=**

Warm ischemia Time: (include Anastomotic time) min **ST=**

Total Cold ischemia Time: (if pumped, include pump time) hrs **ST=**

Warm ischemia Time: (include Anastomotic time) min **ST=**

Kidney(s) received on:

Ice

Pump

Received on ice:

Stayed on ice

Put on pump

Received on pump:

Stayed on pump

Put on ice

If put on pump or stayed on pump:

Final resistance at transplant: mmHg/
(ml/min) **ST=**

Final flow rate at transplant: cc's/min **ST=**

Incidental Tumor found at time of Transplant: YES NO UNK

Oncocytoma

If yes, specify tumor type:

Specify:

Renal Cell Carcinoma
 Carcinoid
 Adenoma
 Transitional Cell Carcinoma
 Other Primary Kidney Tumor, Specify.

Clinical Information : POST TRANSPLANT

Graft Status: Functioning Failed

Resumed Maintenance Dialysis: YES NO

Date Maintenance Dialysis Resumed:

Select a Dialysis Provider:

State: ESRD Network:

Provider #:

Provider Name:

Date of Graft Failure:

Primary Cause of Graft Failure:

HYPERACUTE REJECTION
 ACUTE REJECTION
 PRIMARY FAILURE
 GRAFT THROMBOSIS
 INFECTION
 SURGICAL COMPLICATIONS
 UROLOGICAL COMPLICATIONS
 RECURRENT DISEASE
 OTHER SPECIFY CAUSE

Specify:

Contributory causes of graft failure:

Acute Rejection: YES NO UNK

Graft Thrombosis: YES NO UNK

Infection: YES NO UNK

Surgical Complications: YES NO UNK

Urological Complications: YES NO UNK

Recurrent Disease: YES NO UNK

Other:

Most Recent Serum Creatinine Prior to Discharge: mg/dl **ST=**

Kidney Produced > 40ml of Urine in First 24 Hours: YES NO

Patient Need Dialysis within First Week: YES NO

Creatinine decline by 25% or more in first 24 hours on 2 separate samples: YES NO

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
 Biopsy not done

Was biopsy done to confirm acute rejection:

Yes, rejection confirmed
 Yes, rejection not confirmed

Height: ft. in. cm **%ile ST=**

Weight: lbs kg %ile ST=

BMI: %ile

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="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="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Immunosuppressive Medication, Specify	<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"/>
FTY 720	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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