

**Records** ?

**Transplant Candidate Registration Worksheet**

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 08/31/2007

**Provider Information**

Recipient Center:

**Candidate Information**

Organ Registered: Date Patient Placed on List:

Last Name:  First Name:  MI:

Previous Surname:

SSN:  Gender:  Male  Female

HIC:  DOB:

State of Permanent Residence:

Permanent ZIP Code:  -

Is Patient waiting in permanent ZIP code:  YES  NO  UNK

**Ethnicity/Race:**  
(select all origins that apply)

- |   |  |
|---|--|
| <p>American Indian or Alaska Native</p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Eskimo</p> <p><input type="checkbox"/> Aleutian</p> <p><input type="checkbox"/> Alaska Indian</p> <p><input type="checkbox"/> American Indian or Alaska Native: Other</p> <p><input type="checkbox"/> American Indian or Alaska Native: Not Specified/Unknown</p> <p>Black or African American</p> <p><input type="checkbox"/> African American</p> <p><input type="checkbox"/> African (Continental)</p> <p><input type="checkbox"/> West Indian</p> <p><input type="checkbox"/> Haitian</p> <p><input type="checkbox"/> Black or African American: Other</p> <p><input type="checkbox"/> Black or African American: Not Specified/Unknown</p> <p>Native Hawaiian or Other Pacific Islander</p> <p><input type="checkbox"/> Native Hawaiian</p> <p><input type="checkbox"/> Guamanian or Chamorro</p> <p><input type="checkbox"/> Samoan</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander: Other</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander: Not Specified/Unknown</p> | <p>Asian</p> <p><input type="checkbox"/> Asian Indian/Indian Sub-Continent</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Filipino</p> <p><input type="checkbox"/> Japanese</p> <p><input type="checkbox"/> Korean</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Asian: Other</p> <p><input type="checkbox"/> Asian: Not Specified/Unknown</p> <p>Hispanic/Latino</p> <p><input type="checkbox"/> Mexican</p> <p><input type="checkbox"/> Puerto Rican (Mainland)</p> <p><input type="checkbox"/> Puerto Rican (Island)</p> <p><input type="checkbox"/> Cuban</p> <p><input type="checkbox"/> Hispanic/Latino: Other</p> <p><input type="checkbox"/> Hispanic/Latino: Not Specified/Unknown</p> <p>White</p> <p><input type="checkbox"/> European Descent</p> <p><input type="checkbox"/> Arab or Middle Eastern</p> <p><input type="checkbox"/> North African (non-Black)</p> <p><input type="checkbox"/> White: Other</p> <p><input type="checkbox"/> White: Not Specified/Unknown</p> |
|---|--|

Citizenship:  U.S. CITIZEN  
 RESIDENT ALIEN  
 NON-RESIDENT ALIEN, Year Entered US

Year of Entry to the U.S.

Highest Education Level:  NONE  
 GRADE SCHOOL (0-8)  
 HIGH SCHOOL (9-12)  
 ATTENDED COLLEGE/TECHNICAL SCHOOL  
 ASSOCIATE/BACHELOR DEGREE

	<input type="radio"/> POST-COLLEGE GRADUATE DEGREE <input type="radio"/> N/A (< 5 YRS OLD) <input type="radio"/> UNKNOWN
<b>Medical Condition at time of listing:</b>	<input type="radio"/> IN INTENSIVE CARE UNIT <input type="radio"/> HOSPITALIZED NOT IN ICU <input type="radio"/> NOT HOSPITALIZED
<b>Patient on Life Support:</b>	<input type="radio"/> YES <input type="radio"/> NO  <input type="checkbox"/> Extra Corporeal Membrane Oxygenation <input type="checkbox"/> Intra Aortic Balloon Pump <input type="checkbox"/> Prostacyclin Infusion <input type="checkbox"/> Prostacyclin Inhalation <input type="checkbox"/> Inhaled NO <input type="checkbox"/> Ventilator <input type="checkbox"/> Other Mechanism, Specify Specify: <input type="text"/>
<b>Functional Status:</b>	<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
<b>Physical Capacity:</b>	<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
<b>Working for income:</b>	<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: <ul style="list-style-type: none"> <li><input type="radio"/> Patient Choice - Homemaker</li> <li><input type="radio"/> Patient Choice - Student Full Time/Part Time</li> <li><input type="radio"/> Patient Choice - Retired</li> <li><input type="radio"/> Patient Choice - Other</li> <li><input type="radio"/> Unknown</li> </ul> If Yes: <ul style="list-style-type: none"> <li><input type="radio"/> Working Full Time</li> <li><input type="radio"/> Working Part Time due to Demands of Treatment</li> <li><input type="radio"/> Working Part Time due to Disability</li> <li><input type="radio"/> Working Part Time due to Insurance Conflict</li> <li><input type="radio"/> Working Part Time due to Inability to Find Full Time Work</li> <li><input type="radio"/> Working Part Time due to Patient Choice</li> <li><input type="radio"/> Working Part Time Reason Unknown</li> <li><input type="radio"/> Working, Part Time vs. Full Time Unknown</li> <li><input type="radio"/> Within One Grade Level of Peers</li> <li><input type="radio"/> Delayed Grade Level</li> </ul>



**Drug Treated Systemic Hypertension:**  YES  NO  UNK  
**Symptomatic Cerebrovascular Disease:**  YES  NO  UNK  
**Symptomatic Peripheral Vascular Disease:**  YES  NO  UNK

**Any previous Malignancy:**  YES  NO  UNK

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

Specify:

**Most Recent Serum Creatinine:**  mg/dl **ST=**   
**Total Serum Albumin:**  g/dl **ST=**

**Lung Medical Factors**

**Pulmonary Status:**

**FVC:**  %predicted **ST=**   
**FeV1:**  %predicted **ST=**   
**pCO2:**  mm/Hg **ST=**   
**FeV1(L)/FVC(L):**  **ST=**   
**O2 Requirement at Rest:**  L/min **ST=**

**IV Treated Pulmonary Sepsis Episode >= 2 in last 12 months:**  YES  NO  UNK  
**Corticosteroid Dependency >= 5mg/day:**  YES  NO  UNK  
**Six minute walk distance:**  # of feet  
**Pan-Resistant Bacterial Lung Infection:**  YES  NO  UNK  
**Infection Requiring IV Drug Therapy within 2/wks prior to listing:**  YES  NO  UNK

**Heart/Lung Medical Factors:**

Most Recent Hemodynamics:		Inotropes/Vasodilators:	
PA (sys) mm/Hg:	<input type="text"/> <b>ST=</b> <input type="text"/>	<input type="radio"/> YES	<input type="radio"/> NO
PA (dia) mm/Hg:	<input type="text"/> <b>ST=</b> <input type="text"/>	<input type="radio"/> YES	<input type="radio"/> NO
PA (mean) mm/Hg:	<input type="text"/> <b>ST=</b> <input type="text"/>	<input type="radio"/> YES	<input type="radio"/> NO
PCW (mean) mm/Hg:	<input type="text"/> <b>ST=</b> <input type="text"/>	<input type="radio"/> YES	<input type="radio"/> NO
CO L/min:	<input type="text"/> <b>ST=</b> <input type="text"/>	<input type="radio"/> YES	<input type="radio"/> NO

**History of Cigarette Use:**  YES  NO  
 0-10  
 11-20

If Yes, Check # pack years:

21-30

31-40

41-50

>50

Unknown pack years

Duration of Abstinence:

0-2 months

3-12 months

13-24 months

25-36 months

37-48 months

49-60 months

>60 months

Unknown duration

**Other Tobacco Use:**  YES  NO  UNK

**Prior Cardiac Surgery (non-transplant):**  YES  NO  UNK

If yes, check all that apply:

CABG

Valve Replacement/Repair

Congenital

Left Ventricular Remodeling

Other, specify

Specify:

**Prior Lung Surgery (non-transplant):**  YES  NO  UNK

If yes, check all that apply:

Pneumoreduction

Pneumothorax Surgery-Nodule

Pneumothorax Decortication

Lobectomy

Pneumonectomy

Left Thoracotomy

Right Thoracotomy

Other, specify

Specify:

**UNOS View Only**

**Comments:**