

Records ?

Pancreas 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"/>
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

Height: ft. in. cm **%ile ST=**
Weight: lbs kg **%ile ST=**
BMI: **%ile**

Previous Transplants:

Previous Transplant Organ	Previous Transplant Date	Previous Transplant Graft Fail Date

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.

Pretransplant Dialysis: YES NO UNK

If Yes, Date first Dialyzed: ST=

Average Daily Insulin Units: ST=

Serum Creatinine at Time of Tx: mg/dl ST=

Viral Detection

Have any of the following viruses ever been tested for:
(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
	<input type="radio"/> Positive
	<input type="radio"/> Negative
Antibody:	<input type="radio"/> Not Done
	<input type="radio"/> UNK/Cannot Disclose
	<input type="radio"/> Positive
	<input type="radio"/> Negative
RNA:	<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
	<input type="radio"/> Positive
	<input type="radio"/> Negative
IgG:	<input type="radio"/> Not Done
	<input type="radio"/> UNK/Cannot Disclose
	<input type="radio"/> Positive
	<input type="radio"/> Negative
IgM:	<input type="radio"/> Not Done
	<input type="radio"/> UNK/Cannot Disclose
	<input type="radio"/> Positive
	<input type="radio"/> Negative
Nucleic Acid Testing:	<input type="radio"/> Not Done
	<input type="radio"/> UNK/Cannot Disclose
	<input type="radio"/> Positive
	<input type="radio"/> Negative
Culture:	<input type="radio"/> Not Done
	<input type="radio"/> UNK/Cannot Disclose

HBV: YES NO

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

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 Type:	<input type="text"/>
Surgical Information:	
If a simultaneous Tx with another organ, was the Pancreas revascularized before or after other organs:	<input type="radio"/> Before <input type="radio"/> Simultaneous <input type="radio"/> After <input type="radio"/> Not Applicable
Surgical Incision:	<input type="radio"/> Midline <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Other
Graft Placement:	<input type="radio"/> INTRA-PERITONEAL <input type="radio"/> RETRO-PERITONEAL <input type="radio"/> PARTIAL INTRA/RETRO-PERITONEAL <input type="radio"/> PANCREAS ALONE <input type="radio"/> CLUSTER
Operative Technique:	<input type="radio"/> MULTI-ORGAN NON-CLUSTER <input type="radio"/> PANCREAS AFTER KIDNEY <input type="radio"/> PANCREAS WITH KIDNEY DIFFERENT DONOR <input type="radio"/> ENTERIC W/ROUX-EN-Y <input type="radio"/> ENTERIC W/O ROUX-EN-Y
Duct Management:	<input type="radio"/> CYSTOSTOMY <input type="radio"/> DUCT INJECTION IMMEDIATE <input type="radio"/> DUCT INJECTION DELAYED <input type="radio"/> OTHER SPECIFY
Specify:	<input type="text"/>
Venous Vascular Management:	<input type="radio"/> SYSTEMIC SYSTEM (ILIAC:CAVA) <input type="radio"/> PORTAL SYSTEM (PORTAL OR TRIBUTARIES) <input type="radio"/> CELIAC WITH PANCREAS <input type="radio"/> Y-GRAFT TO SPA & SMA
Arterial Reconstruction:	<input type="radio"/> SPA TO SMA DIRECT <input type="radio"/> SPA TO SMA WITH INTERPOSITION <input type="radio"/> SPA ALONE <input type="radio"/> OTHER SPECIFY
Specify:	<input type="text"/>

Venous Extension Graft: YES NO

Preservation Information:

Total Pancreas Preservation Time (include Cold, Warm, Anastomotic time): hrs **ST=**

Clinical Information : POST TRANSPLANT

Pancreas Graft Status: Functioning Partial Function Failed

Method of blood sugar control: (check all that apply) Insulin Oral medication

Date insulin/medication first resumed:

Date of Graft Failure:

Pancreas Graft Removed: YES NO UNK

Date Pancreas Graft Removed:

Pancreas Primary Cause of Graft Failure:

Specify:

Contributory causes of graft failure:

Pancreas Graft/Vascular Thrombosis: YES NO UNK

Pancreas Infection: YES NO UNK

Bleeding: YES NO UNK

Anastomotic Leak: YES NO UNK

Hyperacute Rejection: YES NO UNK

Pancreas Acute Rejection: YES NO UNK

Biopsy Proven Isletitis: YES NO UNK

Pancreatitis: YES NO UNK

Other:

Pancreas Transplant Complications:
(Not leading to graft failure.)

Pancreatitis: YES NO UNK

Anastomotic Leak: YES NO UNK

Abcess or Local Infection: YES NO UNK

Pancreas Transplant Complications: Other

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

Treatment

Biological or Anti-viral Therapy: YES NO Unknown/Cannot disclose

If Yes, check all that apply:

Acyclovir (Zovirax)

Cytogamn (CMV)

Gamimune

Gammagard

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 (Epiriv) (for treatment of Hepatitis B)
	<input type="checkbox"/> Other, Specify
Specify:	<input type="text"/>
Specify:	<input type="text"/>

Other therapies: YES NO

If Yes, check all that apply:

Photopheresis

Plasmapheresis

Total Lymphoid Irradiation (TLI)

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"/>
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"/>