

Records

Adult Kidney Transplant Recipient Follow-Up Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 10/31/2010

Note: These worksheets are provided to function as a guide to what data will be required in the online TIEDI[®] application. Currently in the worksheet, a red asterisk is displayed by fields that are required, independent of what other data may be provided. Based on data provided through the online TIEDI[®] application, additional fields that are dependent on responses provided in these required fields may become required as well. However, since those fields are not required in every case, they are not marked with a red asterisk.

Recipient Information	
Name:	DOB:
SSN:	Gender:
HIC:	Tx Date:
Previous Follow-Up:	Previous Px Stat Date:
Transplant Discharge Date:	<input type="text"/>
State of Permanent Residence: *	<input type="text"/>
Zip Code: *	<input type="text"/> - <input type="text"/>

Provider Information	
Recipient Center:	
Followup Center:	
Physician Name: *	<input type="text"/>
NPI#: *	<input 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 type="text"/>

Donor Information	
UNOS Donor ID #:	
Donor Type:	

Patient Status	
Date: Last Seen, Retransplanted or Death *	<input type="text"/>
Patient Status: *	<input checked="" type="radio"/> LIVING <input type="radio"/> DEAD

RETRANSPLANTED

Primary Cause of Death:

Specify:

Contributory Cause of Death:

Specify:

Contributory Cause of Death:

Specify:

Hospitalizations:

Has the patient been hospitalized since the last patient status date:*

YES NO UNK

Number of Hospitalizations:

St=

TRR
Diagnosis:

Disease Recurrence:

- No recurrence
- Suspected recurrence (not confirmed or unknown is confirmed by biopsy)
- Biopsy confirmed recurrence
- Unknown

Noncompliance:

Was there evidence of noncompliance with immunosuppression medication during this follow-up period that compromised the patient's recovery:

YES NO UNK

Functional Status:*

Physical Capacity:

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

Working for income:*

YES NO UNK

If No, Not Working Due To:

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/ High School graduate
- Status Unknown

Primary Insurance at Follow-up:*

Specify:

Clinical Information

Height: ft. in. cm %ile ST=

Weight: lbs. kg %ile ST=

BMI: kg/m² %ile

Urine Protein Found By Any Method:

YES NO UNK

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

If yes, insulin dependent: YES NO UNK

Graft Status: * Functioning Failed

If death is indicated for the recipient, and the death was a result of some other factor unrelated to graft failure, select Functioning.

If Functioning, Most Recent Serum Creatinine: mg/dl St=

Date of Failure:

Primary Cause of Graft Failure:

Other, Specify:

Contributory causes of graft failure:

Acute Rejection YES NO UNK

Chronic Rejection YES NO UNK

Graft Thrombosis YES NO UNK

Infection YES NO UNK

Urological Complications YES NO UNK

Patient Noncompliance YES NO UNK

Recurrent Disease YES NO UNK

BK (Polyoma) Virus YES NO UNK

Other, Specify:

NO

YES, RESUMED MAINTENANCE DIALYSIS

Dialysis Since Last Follow-Up: * YES, NO MAINTENANCE RESUMPTION

YES, MAINTENANCE RESUMPTION UNKNOWN

UNKNOWN

Date Maintenance Dialysis Resumed:

Select a Dialysis Provider:

Provider #:

Provider Name:

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

Post Transplant Malignancy:*

YES NO UNK

Donor Related:

YES NO UNK

Recurrence of Pre-Tx Tumor:

YES NO UNK

Post Tx De Novo Solid Tumor:

YES NO UNK

De Novo Lymphoproliferative disease and Lymphoma:

YES NO UNK

Treatment

Biological or Anti-viral therapy:

YES NO Unknown/Cannot disclose

If Yes, check all that apply:

- Acyclovir (Zovirax)
- Cytogam (CMV)
- Gamimune
- Gammagard
- Ganciclovir (Cytovene)
- Valgancyclovir (Valcyte)
- HBIG (Hepatitis B Immune Globulin)
- Flu Vaccine (Influenza Virus)

Lamivudine (Epivir) (for treatment of Hepatitis B)

Valacyclovir (Valtrex)

Other, Specify

Specify: *

Specify:

Treatment for BK (polyoma) virus:

YES NO

Yes, Immunosuppression reduction

Yes, Cidofovir

Yes, IVIG

Yes, Type Unknown

Yes, Other, Specify

If Yes, check all that apply:

Specify: *

Other therapies:

YES NO

Photopheresis

Plasmapheresis

Total Lymphoid Irradiation (TLI)

If Yes, check all that apply:

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 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, *for varying periods of time which may be either long-term or intermediate term with a tapering of the dosage until the drug is either eliminated or replaced by another long-term maintenance drug* (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 *for varying periods of time which may be either long-term or intermediate term with a tapering of the dosage until the drug is either eliminated or replaced by another long-term maintenance drug* (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.**

	Prev Maint	Curr Maint	AR
Steroids (Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atgam (ATG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OKT3 (Orthoclone, Muromonab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thymoglobulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simulect - Basiliximab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zenapax - Daclizumab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azathioprine (AZA, Imuran)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EON (Generic Cyclosporine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gengraf (Abbott Cyclosporine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other generic Cyclosporine, specify brand: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neoral (CyA-NOF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandimmune (Cyclosporine A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mycophenolate Mofetil (MMF, Cellcept, RS61443)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Tacrolimus (Prograf, FK506)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Modified Release Tacrolimus FK506E (MR4)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sirolimus (RAPA, Rapamycin, Rapamune)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Myfortic (Mycophenolate Sodium)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Other Immunosuppressive Medications

	Prev Maint	Curr Maint	AR
Campath - Alemtuzumab (anti-CD52)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cyclophosphamide (Cytoxan)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Leflunomide (LFL, Arava)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Other Immunosuppressive Medication, Specify <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rituximab	<input checked="" type="checkbox"/>	<input checked="" 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"/>
FTY 720	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other Immunosuppressive Medication, Specify <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

UNOS View Only

Comments: