

Records ?

Thoracic - Lung 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:	
Physician Name:	<input type="text"/>
Physician UPIN#:	<input type="text"/>
Surgeon Name:	<input type="text"/>
Surgeon 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"/>
	<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:	<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"/> 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: <input 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)

Unknown

Working for income:

YES NO UNK

Disability

Demands of Treatment

Insurance Conflict

Inability to Find Work

If No, Not Working Due To:

Patient Choice - Homemaker

Patient Choice - Student Full Time/Part Time

Patient Choice - Retired

Patient Choice - Other

Unknown

Working Full Time

Working Part Time due to Demands of Treatment

Working Part Time due to Disability

If Yes:

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

Within One Grade Level of Peers

Delayed Grade Level

Academic Progress:

Special Education

Not Applicable < 5 years old

Status Unknown

Full academic load

Reduced academic load

Academic Activity Level:

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.

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): YES NO UNK

Antibody:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

RNA:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

CMV: YES NO

Test

Result

Was there clinical disease: YES NO UNK

IgG:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

IgM: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Nucleic Acid Testing: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Culture: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HBV: YES NO

Test	Result
Was there clinical disease:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK

Liver Histology: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Core Antibody: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

Surface Antigen: Positive
 Negative
 Not Done
 UNK/Cannot Disclose

HBV DNA: Positive
 Negative

- Not Done
- UNK/Cannot Disclose

HCV:

- YES NO

Test

Result

Was there clinical disease:

- YES NO UNK

Liver Histology:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Antibody:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

RIBA:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

HCV RNA:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

EBV:

- YES NO

Test

Result

Was there clinical disease:

- YES NO UNK

IgG:

- Positive
- Negative
- Not Done
- UNK/Cannot Disclose
- Positive

- IgM: Negative
 Not Done
 UNK/Cannot Disclose
 Positive
- EBV DNA: Negative
 Not Done
 UNK/Cannot Disclose

Most Recent Hemodynamics:

Inotropes/Vasodilators:

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

Most Recent Serum Creatinine:	<input type="text"/> mg/dl	ST= <input type="text"/>
Most Recent Total Bilirubin:	<input type="text"/> mg/dl	ST= <input type="text"/>
Oxygen Requirement at Rest:	<input type="text"/> L/min	ST= <input type="text"/>
Chronic Steroid Use:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK	
Pulmonary Status (Give most recent value):		
FVC:	<input type="text"/> %predicted:	ST= <input type="text"/>
FeV1:	<input type="text"/> %predicted:	ST= <input type="text"/>
pCO2:	<input type="text"/> mm/Hg:	ST= <input type="text"/>

Events occurring between listing and transplant:

Transfusions: YES NO UNK

Pulmonary Embolism: YES NO UNK

Infection Requiring IV Therapy within 2 wks prior to Tx: YES NO UNK

Cerebrovascular Event: YES NO UNK

Dialysis: YES NO UNK

Implantable Defibrillator: 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:

Episode of Ventilatory Support: YES NO UNK

If yes, indicate most recent timeframe:

- At time of transplant
- Within 3 months of transplant
- >3 months prior to transplant

Tracheostomy: YES NO UNK

- NO PREVIOUS PREGNANCY
- 1 PREVIOUS PREGNANCY

Previous Pregnancies:

- 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

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:

- SINGLE LEFT LUNG
- SINGLE RIGHT LUNG
- BILATERAL SEQUENTIAL LUNG
- EN-BLOC DOUBLE LUNG
- LOBE, RIGHT
- LOBE, LEFT

Was this a retransplant due to failure of a previous thoracic graft:

- YES NO

Total Organ Ischemia Time (include cold, warm and anastomotic time):

Heart, Heart-Lung:

 min ST=

Left Lung: min ST=

Right Lung: min ST=

Incidental Tumor found at time of Transplant: YES NO UNK

Adenoma

Carcinoma

Carcinoid

Lymphoma

Harmartoma

Other Primary Lung Tumor, Specify

If yes, specify tumor type:

Specify:

Clinical Information : POST TRANSPLANT

Graft Status: Functioning Failed

Date of Graft Failure:

Primary Non-Function

Primary Cause of Graft Failure: Acute Rejection

Chronic Rejection/Atherosclerosis

Events Prior to Discharge:

Any Drug Treated Infection: YES NO UNK

Stroke: YES NO UNK

Dialysis: YES NO UNK

Cardiac Re-Operation: YES NO UNK

Other Surgical Procedures: YES NO UNK

No

Ventilator support for <= 48 hours

Ventilator support for >48 hours but < 5 days

Ventilator support >= 5 days

Ventilator support, duration unknown

Unknown Status

Ventilator Support:

Reintubated: YES NO UNK

Permanent Pacemaker: YES NO UNK

Chest drain >2 weeks: YES NO UNK

Airway Dehiscence: YES NO UNK

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

Was biopsy done to confirm acute rejection: Biopsy not done
 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)
- Valgancyclovir (Valcyte)
- HBIG (Hepatitis B Immune Globulin)
- Flu Vaccine (Influenza Virus)
- Lamivudine (Epivir) (for treatment of Hepatitis B)
- Other, Specify

Specify:

Specify:

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"/>