

## Records ?

### Thoracic - Heart/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:**

Specify:

**Contributory Cause of Death:**

Specify:

**Transplant Hospitalization:**

**Date of Admission to Tx Center:**

**Date of Discharge from Tx Center:**

**Was patient hospitalized during the last 90 days prior to the transplant admission:**  YES  NO  UNK

**Medical Condition:**

IN INTENSIVE CARE UNIT

HOSPITALIZED NOT IN ICU

NOT HOSPITALIZED

**Patient on Life Support:**  YES  NO

Extra Corporeal Membrane Oxygenation

Intra Aortic Balloon Pump

Prostacyclin Infusion

Prostacyclin Inhalation

Inhaled NO

Ventilator

Other Mechanism

Specify:

**Patient on Ventricular Assist Device**

NONE

LVAD

RVAD

TAH

LVAD+RVAD

Life Support: VAD Brand1

Specify:

Life Support: VAD Brand2

Specify:

**Functional Status:**

- Performs activities of daily living with NO assistance.
- Performs activities of daily living with SOME assistance.
- Performs activities of daily living with TOTAL assistance.
- Not Applicable (example: Patient hospitalized, < 1 year old)
- 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.*

**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:

- YES
- NO
- UNK

Liver Histology:

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

- Core Antibody:
- 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: | <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK                                                                                                                                        |
| Liver Histology:            | <ul style="list-style-type: none"> <li><input type="radio"/> Positive</li> <li><input type="radio"/> Negative</li> <li><input type="radio"/> Not Done</li> <li><input type="radio"/> UNK/Cannot Disclose</li> </ul> |
| Antibody:                   | <ul style="list-style-type: none"> <li><input type="radio"/> Positive</li> <li><input type="radio"/> Negative</li> <li><input type="radio"/> Not Done</li> <li><input type="radio"/> UNK/Cannot Disclose</li> </ul> |
| RIBA:                       | <ul style="list-style-type: none"> <li><input type="radio"/> Positive</li> <li><input type="radio"/> Negative</li> <li><input type="radio"/> Not Done</li> <li><input type="radio"/> UNK/Cannot Disclose</li> </ul> |
| HCV RNA:                    | <ul style="list-style-type: none"> <li><input type="radio"/> Positive</li> <li><input type="radio"/> Negative</li> <li><input type="radio"/> Not Done</li> <li><input type="radio"/> UNK/Cannot Disclose</li> </ul> |

**EBV:**

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

EBV DNA:

Positive  
 Negative  
 Not Done  
 UNK/Cannot Disclose

**Most Recent Hemodynamics:**

**Inotropes/Vasodilators:**

PA (sys)mm/Hg:

ST=

YES  NO

PA(dia) mm/Hg:

ST=

YES  NO

PA(mean) mm/Hg:

ST=

YES  NO

PCW(mean) mm/Hg:

ST=

YES  NO

CO L/min:

ST=

YES  NO

Most Recent Serum Creatinine:

 mg/dl

ST=

Most Recent Total Bilirubin:

 mg/dl

ST=

Oxygen Requirement at Rest:

 L/min

ST=

Chronic Steroid Use:  YES  NO  UNK

**Pulmonary Status (Give most recent value):**

FVC:  %predicted: ST=

FeV1:  %predicted: ST=

pCO2:  mm/Hg: ST=

**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

- CABG
- Valve Replacement/Repair
- Congenital
- Left Ventricular Remodeling
- Other, specify

If yes, check all that apply:

Specify:

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

- Pneumoreduction
- Pneumothorax Surgery-Nodule
- Pneumothorax Decortication
- Lobectomy
- Pneumonectomy
- Left Thoracotomy
- Right Thoracotomy
- Other, specify

If yes, check all that apply:

Specify:

**Episode of Ventilatory Support:**

YES  NO  UNK

At time of transplant

If yes, indicate most recent timeframe:

Within 3 months of transplant

>3 months prior to transplant

**Tracheostomy:**

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

If yes, specify type:

Thyroid

Tongue/Throat/Larynx

Lung

Leukemia/Lymphoma

Type Unknown

Other, specify

Specify:

**Clinical Information : TRANSPLANT PROCEDURE**

**Multiple Organ Recipient**

Procedure Type:  Heart  
 Heart Lung

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

If yes, specify tumor type:

- Adenoma
- Carcinoma
- Carcinoid
- Lymphoma
- Harmartoma
- Other Primary Lung Tumor, Specify

Specify:

**Clinical Information : POST TRANSPLANT**

Graft Status:  Functioning  Failed

Date of Graft Failure:

Primary Cause of Graft Failure:  Primary Non-Function  
 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

Time on inotropes other than Isoproterenol (Isuprel):  days ST=

**Ventilator Support:**

- No
- Ventilator support for <= 48 hours
- Ventilator support for >48 hours but < 5 days
- Ventilator support >= 5 days
- Ventilator support, duration unknown
- Unknown Status

**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)
- Cytogam (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

Photopheresis

If Yes, check all that apply:

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

<b>UNOS View Only</b>	
<b>Comments:</b>	<div style="border: 1px solid gray; height: 60px; width: 100%;"></div>