

**Adult Intestine Transplant Recipient Registration Worksheet**

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	
<b>Name:</b>	<b>DOB:</b>
<b>SSN:</b>	<b>Birth sex:</b>
<b>HIC:</b>	<b>Transplant Date and Time:</b>
<b>State of Permanent Residence: *</b>	<input type="text"/>
<b>Permanent Zip: *</b>	<input type="text"/> - <input type="text"/>

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

Donor Information	
<b>UNOS Donor ID #:</b>	
<b>Recovering OPO:</b>	
<b>Donor Type:</b>	

Patient Status	
<b>Primary Diagnosis: *</b>	<input type="text"/>
Specify:	<input type="text"/>
<b>Secondary Diagnosis:</b>	<input type="text"/>
Specify:	<input type="text"/>
<b>Date: Last Seen, Retransplanted or Death *</b>	<input type="text"/>
<b>Patient Status: *</b>	<input type="radio"/> LIVING <input type="radio"/> DEAD <input type="radio"/> RETRANSPLANTED
<b>Primary Cause of Death:</b>	<input type="text"/>
Specify:	<input type="text"/>
<b>Contributory Cause of Death:</b>	<input type="text"/>
Specify:	<input type="text"/>
<b>Contributory Cause of Death:</b>	<input type="text"/>
Specify:	<input type="text"/>
<b>Transplant Hospitalization:</b>	
<b>Date of Admission to Tx Center: *</b>	<input type="text"/>
<b>Date of Discharge from Tx Center:</b>	<input type="text"/>

Clinical Information : PRETRANSPLANT	
<b>Medical Condition at time of transplant: *</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"/> Ventilator <input type="checkbox"/> Artificial Liver <input type="checkbox"/> Other Mechanism, Specify
Specify:	<input type="text"/>
<b>Functional Status: *</b>	<input type="text"/>

Working for income: \*  YES  NO  UNK

Source of Payment:

Primary: \*

Specify:

Height: \*  ft.  in.  cm ST=

Weight: \*  lbs  kg ST=

BMI:  kg/m<sup>2</sup>

Previous Transplants:

Previous Transplant Organ	Previous Transplant Date	Previous Transplant Graft Fail Date

The three most recent transplants are listed here. Please contact the UNet Help Desk to confirm more than three previous transplants by calling 800-978-4334 or by emailing unethelpdesk@unos.org.

Viral Detection:

HIV Serostatus: \*  Positive  
 Negative  
 Not Done  
 UNK/ Cannot Disclose

CMV Status: \*  Positive  
 Negative  
 Not Done  
 UNK/ Cannot Disclose

HBV Surface Antibody Total: \*  Positive  
 Negative  
 Not Done  
 UNK/ Cannot Disclose

HBV Core Antibody: \*  Positive  
 Negative  
 Not Done  
 UNK/ Cannot Disclose

HBV Surface Antigen: \*  Positive  
 Negative  
 Not Done  
 UNK/ Cannot Disclose

HCV Serostatus: \*  Positive  
 Negative  
 Not Done  
 UNK/ Cannot Disclose

EBV Serostatus: \*  Positive  
 Negative  
 Not Done  
 UNK/ Cannot Disclose

Vaccination Status:

Did the recipient receive Hepatitis B vaccines prior to transplant?: \*  YES  NO  UNK

Reason not vaccinated:

- Immunity
- Medical precaution
- Time constraints
- Patient objection
- Product out of stock
- Other, specify

Specify:

**NAT Results:**

HIV NAT:\*

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

HBV NAT:\*

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

HCV NAT:\*

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

Total Bilirubin:\*

 mg/dl

ST=

Serum Albumin:\*

 g/dl

ST=

Serum Creatinine:\*

 mg/dl

ST=

**Clinical Information : TRANSPLANT PROCEDURE**

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Information:

Intestine Venous Drainage:\*

- Portal  Systemic

Native Viscera Venous Drainage:\*

- Portal  Systemic

Procedure Type:

- Whole Intestine
- Intestine Segment
- Whole Intestine with Pancreas (Technical Reasons)
- Intestine Segment with Pancreas (Technical Reasons)

Organ Type:\*

- Stomach
- Small Intestine
- Duodenum
- Large Intestine

Preservation Information:

Total Ischemic Time (include cold, warm and anastomotic time):\*

 hrs

ST=

Risk Factors:

Recent Septicemia:\*

- YES  NO  UNK

Exhausted Vascular Access:\*

- YES  NO  UNK

Previous Abdominal Surgery:\*

- YES  NO  UNK

Dilated/Non-Functional Bowel Segments:\*

- YES  NO  UNK

Other:

Organ Check-in Information:

Intestine Check-In Date and Time:

Date:  Time:  Military time Time Zone:

ST=

Clinical Information : POST TRANSPLANT

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.

TPN Dependent:  YES  NO

IV Dependent:  YES  NO

Oral Feeding:  YES  NO

Tube Feed:  YES  NO

Date of Graft Failure:

Primary Cause of Graft Failure:  RECURRENT TUMOR  
 ACUTE REJECTION  
 CHRONIC REJECTION  
 TECHNICAL PROBLEMS  
 INFECTION  
 LYMPHOPROLIFERATIVE DISEASE  
 GRAFT VERSUS HOST DISEASE  
 ISCHEMIA/NEC LIKE SYNDROME  
 OTHER SPECIFY

Specify:

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

Immunosuppressive Information

Are any medications given currently for maintenance or anti-rejection:\*  YES  NO

Immunosuppressive Medications

View Immunosuppressive Medications

Definitions Of Immunosuppressive Medications

For each of the immunosuppressive medications listed, select **Ind** (Induction), **Maint** (Maintenance) or **AR** (Anti-rejection) to indicate all medications that were prescribed for the recipient during the initial transplant hospitalization period, and for what reason. If a medication was not given, leave the associated box(es) blank.

**Induction (Ind)** immunosuppression includes all medications given for a short finite period in the perioperative period for the purpose of preventing acute rejection. Though the drugs may be continued after discharge for the first 30 days after transplant, it will not be used long-term for immunosuppressive maintenance. Induction agents are usually polyclonal, monoclonal, or IL-2 receptor antibodies (example: methylprednisolone, Campath, Thymoglobulin, or Simulect). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as anti-rejection therapy if used for this reason. For each induction medication indicated, write the total number of days the drug was actually administered in the space provided. For example, if Simulect was given in 2 doses a week apart then the total number of days would be 2, even if the second dose was given after the patient was discharged.

**Maintenance (Maint)** includes all immunosuppressive medications given before, during or after transplant with the intention to maintain them long-term (example: prednisone, cyclosporine, tacrolimus, mycophenolate mofetil, azathioprine, or Rapamune). This does not include any immunosuppressive medications given to treat rejection episodes, or for induction.

**Anti-rejection (AR)** immunosuppression includes all immunosuppressive medications given for the purpose of treating an acute rejection episode during the initial post-transplant period or during a specific follow-up period, usually up to 30 days after the diagnosis of acute rejection (example: methylprednisolone, 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.

If an immunosuppressive medication other than those listed is being administered (e.g., new monoclonal antibodies), select Ind, 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.**

Drug used for induction, acute rejection, or maintenance

	Ind.	Days	ST	Maint	AR
Steroids (prednisone, methylprednisolone, Solumedrol, Medrol)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drugs used for induction or acute rejection

	Ind.	Days	ST	Maint	AR
Atgam	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Campath (alemtuzumab)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cytosan (cyclophosphamide)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Folex PFS, Mexate-AQ, Rheumatrex)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rituxan (rituximab)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simulect (basiliximab)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thymoglobulin	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Drugs primarily used for maintenance					
	Ind.	Days	ST	Maint	AR
<b>Cyclosporine, select from the following:</b>					
- Gengraf	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Neoral	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Sandimmune	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic cyclosporine	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Imuran (azathioprine, AZA)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leflunomide (LFL)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Mycophenolic acid, select from the following:</b>					
- CellCept (MMF)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic MMF (generic CellCept)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Myfortic (mycophenolic acid)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic Myfortic (generic mycophenolic acid)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>mTOR inhibitors, select from the following:</b>					
- Rapamune (sirolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic sirolimus	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Zortress (everolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nulojix (belatacept)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tacrolimus, select from the following:</b>					
- Astagraf XL (extended release tacrolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Envarsus XR (tacrolimus XR)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Prograf (tacrolimus)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Generic tacrolimus (generic Prograf)	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other drugs					
	Ind.	Days	ST	Maint	AR
Other immunosuppressive medication, specify: <input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other immunosuppressive medication, specify: <input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>