

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

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

Donor Information	
UNOS Donor ID #:	
Recovering OPO:	
Donor Type:	

Patient Status	
Kidney Primary Diagnosis: *	<input type="text"/>
Specify:	<input type="text"/>
Pancreas Primary Diagnosis: *	<input type="text"/>
Specify:	<input type="text"/>
Date: Last Seen, Retransplanted or Death *	<input type="text"/>
Patient Status: *	<input type="radio"/> LIVING <input type="radio"/> DEAD <input type="radio"/> RETRANSPLANTED
Retransplanted organ:	<input type="radio"/> Kidney <input type="radio"/> Pancreas <input type="radio"/> Kidney/Pancreas
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"/>

Clinical Information : PRETRANSPLANT	
Functional Status: *	<input type="text"/>
Cognitive Development: *	<input type="radio"/> Definite Cognitive delay/impairment <input type="radio"/> Probable Cognitive delay/impairment <input type="radio"/> Questionable Cognitive delay/impairment <input type="radio"/> No Cognitive delay/impairment <input type="radio"/> Not Assessed

Motor Development: *

Definite Motor delay/impairment
 Probable Motor delay/impairment
 Questionable Motor delay/impairment
 No Motor delay/impairment
 Not Assessed

Academic Progress: *

Within One Grade Level of Peers
 Delayed Grade Level
 Special Education
 Not Applicable, too young for school/ High School graduate or GED
 Status Unknown

Academic Activity Level: *

Full academic load
 Reduced academic load
 Unable to participate in academics due to disease or condition
 Unable to participate regularly in academics due to dialysis
 Not Applicable, too young for school/ High School graduate or GED
 Status Unknown

Kidney Source of Payment:

Primary: *

Specify: _____

Pancreas Source of Payment:

Primary: *

Specify: _____

Height Measurement Date: _____

Height: * _____ ft. _____ in. _____ cm **ST=**

Weight Measurement Date: _____

Weight: * _____ kg **ST=**

BMI: _____ kg/m²

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.

Pretransplant Dialysis: * YES NO UNK

If Yes, Date of Most Recent Initiation of Chronic Maintenance Dialysis: _____ **ST=**

Average Daily Insulin Units: * _____ units/kg/day **ST=**

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

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

Previous Pregnancies:

- YES
- NO
- NOT APPLICABLE: < 10 years old

Malignancies between listing and transplant: *

- YES
- NO

This question is NOT applicable for patients receiving living donor transplants who were never on the waiting list.

If yes, specify type:

- Skin Melanoma
- Skin Non-Melanoma
- CNS Tumor
- Genitourinary
- Breast
- Thyroid
- Tongue/Throat/Larynx
- Lung
- Leukemia/Lymphoma
- Liver
- Other, specify

Specify:

Bone Disease:

Fracture in the past year (or since last follow-up):*

YES NO UNK

Specify Location and number of fractures:*

- Spine-compression fracture: # of fractures:
- Extremity: # of fractures:
- Other: # of fractures:

AVN (avascular necrosis):*

YES NO UNK

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Type:

Surgical Information:

Graft Placement:*

- INTRA-PERITONEAL
- RETRO-PERITONEAL
- PARTIAL INTRA/RETRO-PERITONEAL

Operative Technique:*

- Simultaneous Kidney-Pancreas
- Cluster
- Multi-Organ Non-Cluster

Duct Management:*

- ENTERIC W/ROUX-EN-Y
- ENTERIC W/O ROUX-EN-Y
- CYSTOSTOMY
- DUCT INJECTION IMMEDIATE
- DUCT INJECTION DELAYED
- OTHER SPECIFY

Specify:

Venous Vascular Management:*

- SYSTEMIC SYSTEM (ILIAC:CAVA)
- PORTAL SYSTEM (PORTAL OR TRIBUTARIES)
- NA/Multi-organ cluster

Arterial Reconstruction:*

- CELIAC WITH PANCREAS
- Y-GRAFT TO SPA & SMA
- SPA TO SMA DIRECT
- SPA TO SMA WITH INTERPOSITION
- SPA ALONE
- OTHER SPECIFY

Specify:

Venous Extension Graft:*

YES NO

Kidney and Pancreas Preservation Information:

Total Cold ischemia Time Right KI(OR EN-BLOC): (if pumped, include pump time): hrs **ST=**

Total Cold Ischemia Time Left KI (If pumped, include pump time): hrs **ST=**

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

Kidney(s) received on:*

- Ice
 Pump
 N/A

Received on ice:

- Stayed on ice
 Put on pump

Received on pump:

- Stayed on pump
 Put on ice

If put on pump or stayed on pump:

Right Kidney Final resistance at transplant: **ST=**

Right Kidney Final flow rate at transplant: **ST=**

Left Kidney Final resistance at transplant: **ST=**

Left Kidney Final flow rate at transplant: **ST=**

Organ Check-in Information:

Pancreas Check-In Date and Time: **Date:** **Time:** Military time **Time Zone:** **ST=**

Left Kidney Check-In Date and Time: **Date:** **Time:** Military time **Time Zone:** **ST=**

Right Kidney Check-In Date and Time: **Date:** **Time:** Military time **Time Zone:** **ST=**

En Bloc Kidneys Check-In Date and Time: **Date:** **Time:** Military time **Time Zone:** **ST=**

Clinical Information : POST TRANSPLANT

Kidney 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.

Resumed Maintenance Dialysis: YES NO

Date Maintenance Dialysis Resumed:

Kidney Date of Graft Failure:

- Kidney Primary Cause of Graft Failure:**
- HYPERACUTE REJECTION
 ACUTE REJECTION
 PRIMARY NON-FUNCTION (GRAFT NEVER FUNCTIONED POST-TRANSPLANT)
 GRAFT THROMBOSIS
 INFECTION
 SURGICAL COMPLICATIONS
 UROLOGICAL COMPLICATIONS
 RECURRENT DISEASE
 OTHER SPECIFY CAUSE

Specify:

Did patient have any acute kidney 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

Is growth hormone therapy used between listing and transplant:* YES NO UNK

Most Recent Serum Creatinine Prior to Discharge: *	<input type="text"/>	mg/dl	ST= <input type="text"/>
Patient Need Dialysis within First Week: *	<input type="radio"/> YES <input type="radio"/> NO		
Pancreas Graft Status: *	<input type="radio"/> Functioning <input type="radio"/> Failed		
If death is indicated for the recipient, report graft status up until the instance of death.			
Patient using either oral medication or diet for blood sugar control: *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Patient on oral medication to control blood sugar? *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Date of medications resumed: *	<input type="text"/>		ST= <input type="text"/>
Patient using diet to control blood sugar: *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Patient on insulin? *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Date insulin resumed: *	<input type="text"/>		ST= <input type="text"/>
Average total insulin dosage per day: *	<input type="text"/>	units/kg/day	ST= <input type="text"/>
Insulin duration of use: *	<input type="text"/>	days	ST= <input type="text"/>
C-peptide value:	<input type="text"/>	ng/mL	ST= <input type="text"/>
HbA1c:	<input type="text"/>	%	ST= <input type="text"/>
Pancreas Date of Graft Failure:	<input type="text"/>		
Pancreas Primary Cause of Graft Failure:	<input type="text"/>		
Pancreas Primary Cause of Graft Failure/Specify:	<input type="text"/>		
Contributory causes of graft failure:			
Pancreas Graft/Vascular Thrombosis:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Pancreas Infection:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Bleeding:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Anastomotic Leak:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Hyperacute Rejection:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Pancreas Acute Rejection:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Biopsy Proven Isletitis:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Pancreatitis:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Other, Specify:	<input type="text"/>		
Did patient have any acute pancreas rejection episodes between transplant and discharge: *	<input type="radio"/> Yes, at least one episode treated with anti-rejection agent		
	<input type="radio"/> Yes, none treated with additional anti-rejection agent		
	<input type="radio"/> No		
Pancreas Transplant Complications: (Not leading to graft failure.)			
Pancreatitis: *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Anastomotic Leak: *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Abscess or Local Infection: *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK		
Other:	<input type="text"/>		
Weight Post Transplant: *	<input type="text"/>	lbs.	<input type="text"/>
	<input type="text"/>	kg	ST= <input type="text"/>

Immunosuppressive Information	
Are any medications given currently for maintenance or anti-rejection: *	<input type="radio"/> YES <input type="radio"/> 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"/>
Cytoxan (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
Cyclosporine, select from the following:					
- 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"/>
Mycophenolic acid, select from the following:					
- 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"/>
mTOR inhibitors, select from the following:					
- 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"/>
Tacrolimus, select from the following:					
- 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"/>

DRAFT ONLY
To preview changes
coming Sept. 14, 2023