Records

Adult Kidney Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant:	IN INTENSIVE CARE UNIT HOSPITALIZED NOT IN ICU NOT HOSPITALIZED
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/ 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 < 5 years old/ High School graduate or GED Status Unknown

Source of Payment:

Primary: *

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

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=

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

Viral Detection:

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

CMV IgG: *
- ○ Positive
- ○ Negative
- ○ Not Done
- ○ UNK/Cannot Disclose

CMV IgM: *
- ○ 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

Was preimplantation kidney biopsy performed at the transplant center:

- YES
- NO

Did patient receive any pretransplant blood transfusions: *

- YES
- NO
- UNK

Any tolerance induction technique used:

- 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

(which may or may not have resulted in a live birth)

Malignancies between listing and transplant: *

- YES
- NO
- UNK

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:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Type:

Kidney Preservation Information:

Total Cold ischemia Time Right KI(OR EN-BLOC): (if pumped, include pump time):	hrs	**ST=**
Total Warm Ischemia Time Right KI (OR EN-BLOC): (Include Anastomotic time):	min	**ST=**
Total Cold ischemia Time Left KI (if pumped, include pump time):	hrs	**ST=**
Total Warm ischemia Time Left KI (include Anastomotic time):	min	**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:

Final resistance at transplant:		ST=
Final flow rate at transplant:		ST=

Incidental Tumor found at time of Transplant: ( ) YES ( ) NO ( ) UNK

If yes, specify tumor type:

- ( ) Oncocytoma
- ( ) Renal Cell Carcinoma
- ( ) Carcinoid
- ( ) Adenoma
- ( ) Transitional Cell Carcinoma
- ( ) Other Primary Kidney Tumor, Specify.

Specify:

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.

Resumed Maintenance Dialysis: ○ YES ○ NO

Date Maintenance Dialysis Resumed:

Select a Dialysis Provider:

Provider #:

Provider Name:

Date of Graft Failure:

Primary Cause of Graft Failure:

- ○ HYPERACUTE REJECTION
- ○ ACUTE REJECTION
- ○ PRIMARY FAILURE
- ○ GRAFT THROMBOSIS
- ○ INFECTION
- ○ SURGICAL COMPLICATIONS
- ○ UROLOGICAL COMPLICATIONS
- ○ RECURRENT DISEASE
- ○ OTHER SPECIFY CAUSE

Specify:

Contributory causes of graft failure:

Acute Rejection: ○ YES ○ NO ○ UNK

Graft Thrombosis: ○ YES ○ NO ○ UNK

Infection: ○ YES ○ NO ○ UNK

Surgical Complications: ○ YES ○ NO ○ UNK

Urological Complications: ○ YES ○ NO ○ UNK

Recurrent Disease: ○ YES ○ NO ○ UNK

Other, Specify:

Most Recent Serum Creatinine Prior to Discharge: mg/dl **ST=**

Kidney Produced > 40ml of Urine in First 24 Hours: ○ YES ○ NO

Patient Need Dialysis within First Week: ○ YES ○ NO

Creatinine decline by 25% or more in first 24 hours on 2 separate samples: ○ YES ○ NO

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

Height: * ft. in. cm ST=

Weight: * lbs kg ST=

BMI: kg/m^2

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
- Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

		Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)		☐			☐	☐
Atgam (ATG)		☐			☐	☐
OKT3 (Orthoclone, Muromonab)		☐			☐	☐
Thymoglobulin		☐			☐	☐
Simulect - Basiliximab		☐			☐	☐
Zenapax - Daclizumab		☐			☐	☐
Azathioprine (AZA, Imuran)		☐			☐	☐
EON (Generic Cyclosporine)		☐			☐	☐
Gengraf (Abbott Cyclosporine)		☐			☐	☐
Other generic Cyclosporine, specify brand:		☐			☐	☐
Neoral (CyA-NOF)		☐			☐	☐
Sandimmune (Cyclosporine A)		☐			☐	☐
CellCept (Mycophenolate Mofetil; MMF)		☐			☐	☐

Generic MMF (Generic CellCept)	☐			☐	☐
Prograf (Tacrolimus, FK506)	☐			☐	☐
Generic Tacrolimus (Generic Prograf)	☐			☐	☐
Advagraf (Tacrolimus Extended or Modified Release)	☐			☐	☐
Nulojix (Belatacept)	☐			☐	☐
Sirolimus (RAPA, Rapamycin, Rapamune)	☐			☐	☐
Myfortic (Mycophenolate Sodium)	☐			☐	☐

Other Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)	☐			☐	☐
Cyclophosphamide (Cytoxan)	☐			☐	☐
Leflunomide (LFL, Arava)	☐			☐	☐
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	☐			☐	☐
Other Immunosuppressive Medication, Specify	☐			☐	☐
Rituximab	☐			☐	☐

Investigational Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Zortress (Everolimus)	☐			☐	☐
Other Immunosuppressive Medication, Specify	☐			☐	☐

Records

Adult Kidney-Pancreas Transplant Recipient Registration Worksheet

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Recipient Information

Name: **DOB:**

SSN: **Gender:**

HIC: **Tx Date:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Kidney Primary Diagnosis: *

Specify:

Pancreas Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Retransplanted organ: Kidney Pancreas Kidney/Pancreas

Primary Cause of Death:

Specify:

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 at time of transplant: *

- IN INTENSIVE CARE UNIT
- HOSPITALIZED NOT IN ICU
- NOT HOSPITALIZED

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/ High School graduate or GED
- Status Unknown

- Full academic load
- Reduced academic load
- Unable to participate in academics due to disease or condition

Academic Activity Level:

- Unable to participate regularly in academics due to dialysis
- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Kidney Source of Payment:

Primary:

Specify:

Secondary:

Pancreas Source of Payment:

Primary:

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

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

Weight: kg **ST=**

BMI: kg/m^2

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: **ST=**

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

Viral Detection:

HIV Serostatus:

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

CMV IgG:

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

CMV IgM:

- 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
Was preimplantation kidney biopsy performed at the transplant center:	○ YES ○ NO
Did patient receive any pretransplant blood tranfusions: *	○ YES ○ NO ○ UNK
Any tolerance induction technique used:	○ YES ○ NO ○ UNK
Previous Pregnancies: * (which may or may not have resulted in a live birth)	○ 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

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:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Type:

Surgical Information:

Was the Pancreas revascularized before or after other organs:

- ○ Before
- ○ Simultaneous
- ○ After
- ○ Not Applicable

Surgical Incision:

- ○ Iliac Fossa PA left/KI right
- ○ Iliac Fossa PA right/KI left
- ○ Left
- ○ Midline
- ○ Right

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 Warm Ischemia Time Right KI (OR EN-BLOC): (Include Anastomotic time):		min	**ST=**	
Total Cold Ischemia Time Left KI (If pumped, include pump time):		hrs	**ST=**	
Total Warm ischemia Time Left KI (Include Anastomotic time):		min	**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:

Final resistance at transplant: ST=

Final flow rate at transplant: ST=

Incidental Tumor found at time of Transplant: YES NO UNK

If yes, specify tumor type:

- Oncocytoma
- Renal Cell Carcinoma
- Carcinoid
- Adenoma
- Transitional Cell Carcinoma
- Other Primary Kidney Tumor, Specify.

Specify:

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:

Select a Dialysis Provider:

Provider #:

Provider Name:

Kidney Date of Graft Failure:

Kidney Primary Cause of Graft Failure:

- HYPERACUTE REJECTION
- ACUTE REJECTION
- PRIMARY FAILURE
- GRAFT THROMBOSIS
- INFECTION
- SURGICAL COMPLICATIONS
- UROLOGICAL COMPLICATIONS
- RECURRENT DISEASE
- OTHER SPECIFY CAUSE

Specify:

Contributory causes of graft failure:

Kidney Acute Rejection: YES NO UNK

Kidney Graft Thrombosis: YES NO UNK

Kidney Infection: YES NO UNK

Surgical Complications: ○ YES ○ NO ○ UNK

Urological Complications: ○ YES ○ NO ○ UNK

Recurrent Disease: ○ YES ○ NO ○ UNK

Other, 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

Was biopsy done to confirm acute rejection:

○ Biopsy not done

○ Yes, rejection confirmed

○ Yes, rejection not confirmed

Most Recent Serum Creatinine Prior to Discharge: * mg/dl **ST=**

Kidney Produced > 40ml of Urine in First 24 Hours: ○ YES ○ NO

Patient Need Dialysis within First Week: * ○ YES ○ NO

Creatinine Decline by 25% or More in First 24 Hours on 2 separate samples: ○ YES ○ NO

Pancreas Graft Status: * ○ Functioning ○ Partial Function ○ Failed

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

Method of blood sugar control: (check all that apply)

☐ Insulin

☐ Oral medication

☐ Diet

☐ No Treatment

Date Insulin/Medication Resumed:

Pancreas Date of Graft Failure:

Pancreas Graft Removed: ○ YES ○ NO ○ UNK

If Yes, Date Pancreas Graft Removed:

Pancreas Primary Cause of Graft Failure:

Pancreas Primary Cause of Graft Failure/Specify:

Contributory causes of graft failure:

Pancreas Graft/Vascular Thrombosis: ○ YES ○ NO ○ UNK

Pancreas Infection: ○ YES ○ NO ○ UNK

Bleeding: ○ YES ○ NO ○ UNK

Anastomotic Leak:	YES NO UNK
Hyperacute Rejection:	YES NO UNK
Pancreas Acute Rejection:	YES NO UNK
Biopsy Proven Isletitis:	YES NO UNK
Pancreatitis:	YES NO UNK
Other, Specify:	

Did patient have any acute pancreas 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

Pancreas Transplant Complications:
(Not leading to graft failure.)

Pancreatitis:*	YES NO UNK
Anastomotic Leak:*	YES NO UNK
Abscess or Local Infection:*	YES NO UNK
Other:	

Weight Post Transplant:* lbs. kg ST=

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**

☐ **Valacyclovir (Valtrex)**

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)	☐			☐	☐
Atgam (ATG)	☐			☐	☐
OKT3 (Orthoclone, Muromonab)	☐			☐	☐
Thymoglobulin					

Simulect - Basiliximab						
Zenapax - Daclizumab						
Azathioprine (AZA, Imuran)						
EON (Generic Cyclosporine)						
Gengraf (Abbott Cyclosporine)						
Other generic Cyclosporine, specify brand:						
Neoral (CyA-NOF)						
Sandimmune (Cyclosporine A)						
CellCept (Mycophenolate Mofetil; MMF)						
Generic MMF (Generic CellCept)						
Prograf (Tacrolimus, FK506)						
Generic Tacrolimus (Generic Prograf)						
Advagraf (Tacrolimus Extended or Modified Release)						
Nulojix (Belatacept)						
Sirolimus (RAPA, Rapamycin, Rapamune)						
Myfortic (Mycophenolate Sodium)						

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

	☐			☐	☐

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)		☐			☐	☐
Other Immunosuppressive Medication, Specify		☐			☐	☐

Records

Adult Pancreas Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant:*	IN INTENSIVE CARE UNIT HOSPITALIZED NOT IN ICU NOT HOSPITALIZED
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/ 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 Not Applicable < 5 years old/ High School graduate or GED Status Unknown
Source of Payment:	

Primary:

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

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

Weight: lbs kg **ST=**

BMI: kg/m^2

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: **ST=**

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

Viral Detection:

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

CMV IgG:
- **Positive**
- **Negative**
- **Not Done**
- **UNK/Cannot Disclose**

CMV IgM:
- **Positive**
- **Negative**
- **Not Done**
- **UNK/Cannot Disclose**

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

- **Positive**
- **Negative**

HBV Surface Antigen:
- Not Done
- UNK/Cannot Disclose

HCV Serostatus:
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

EBV Serostatus:
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Malignancies between listing and transplant: YES NO UNK

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:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Type:

Surgical Information:

If a simultaneous Tx with another organ, was the Pancreas revascularized before or after other organs:
- Before
- Simultaneous
- After
- Not Applicable

Surgical Incision:	○ Left ○ Midline ○ Other ○ Right
Graft Placement:*	○ INTRA-PERITONEAL ○ RETRO-PERITONEAL ○ PARTIAL INTRA/RETRO-PERITONEAL
Operative Technique:*	○ PANCREAS ALONE ○ CLUSTER ○ MULTI-ORGAN NON-CLUSTER ○ PANCREAS AFTER KIDNEY ○ PANCREAS WITH KIDNEY DIFFERENT DONOR
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

Preservation Information:

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

Clinical Information : POST TRANSPLANT

Pancreas Graft Status: * ○ Functioning ○ Partial Function ○ Failed

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

Method of blood sugar control: (check all that apply)

- ☐ Insulin
- ☐ Oral medication
- ☐ Diet
- ☐ No Treatment

Date insulin/medication first resumed:

Date of Graft Failure:

Pancreas Graft Removed: ○ YES ○ NO ○ UNK

Date Pancreas Graft Removed:

Pancreas Primary Cause of Graft Failure:

Specify:

Contributory causes of graft failure:

Pancreas Graft/Vascular Thrombosis: ○ YES ○ NO ○ UNK

Pancreas Infection: ○ YES ○ NO ○ UNK

Bleeding: ○ YES ○ NO ○ UNK

Anastomotic Leak: ○ YES ○ NO ○ UNK

Hyperacute Rejection: ○ YES ○ NO ○ UNK

Pancreas Acute Rejection: ○ YES ○ NO ○ UNK

Biopsy Proven Isletitis: ○ YES ○ NO ○ UNK

Pancreatitis: ○ YES ○ NO ○ UNK

Other, Specify:

Pancreas Transplant Complications:
(Not leading to graft failure.)

Pancreatitis: * ○ YES ○ NO ○ UNK

Anastomotic Leak: * ○ YES ○ NO ○ UNK

Abscess or Local Infection: * ○ YES ○ NO ○ UNK

Pancreas Transplant Complications: Other

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 ☐ Valacyclovir (Valtrex)
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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

		Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)		☐			☐	☐
Atgam (ATG)		☐			☐	☐
OKT3 (Orthoclone, Muromonab)		☐			☐	☐
Thymoglobulin		☐			☐	☐
Simulect - Basiliximab		☐			☐	☐
Zenapax - Daclizumab		☐			☐	☐
Azathioprine (AZA, Imuran)		☐			☐	☐
EON (Generic Cyclosporine)		☐			☐	☐
Gengraf (Abbott Cyclosporine)		☐			☐	☐
Other generic Cyclosporine, specify brand:		☐			☐	☐
Neoral (CyA-NOF)		☐			☐	☐
Sandimmune (Cyclosporine A)		☐			☐	☐
CellCept (Mycophenolate Mofetil; MMF)		☐			☐	☐
Generic MMF (Generic CellCept)		☐			☐	☐
Prograf (Tacrolimus, FK506)		☐			☐	☐
Generic Tacrolimus (Generic Prograf)		☐			☐	☐

Advagraf (Tacrolimus Extended or Modified Release)	☐			☐	☐
Nulojix (Belatacept)	☐			☐	☐
Sirolimus (RAPA, Rapamycin, Rapamune)	☐			☐	☐
Myfortic (Mycophenolate Sodium)	☐			☐	☐

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)		☐			☐	☐
Cyclophosphamide (Cytoxan)		☐			☐	☐
Leflunomide (LFL, Arava)		☐			☐	☐
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)		☐			☐	☐
Other Immunosuppressive Medication, Specify		☐			☐	☐
Rituximab		☐			☐	☐

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)		☐			☐	☐
Other Immunosuppressive Medication, Specify		☐			☐	☐

Records

Adult Liver Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant:*	○ IN INTENSIVE CARE UNIT ○ HOSPITALIZED NOT IN ICU ○ NOT HOSPITALIZED
Patient on Life Support:*	○ YES ○ NO ☐ Ventilator ☐ Artificial Liver ☐ Other Mechanism, Specify Specify:
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/ 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
- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Source of Payment:

Primary: *

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

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

Weight: * lbs kg **ST=**

BMI: kg/m^2

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 IgG: *

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

CMV IgM: *

- 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

Any tolerance induction technique used: YES NO UNK

Pretransplant Lab Date:

SGPT/ALT: U/L **ST=**

Malignancies between listing and transplant: * YES NO UNK

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
- Hepatocellular Carcinoma
- Other, specify

Specify:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Surgical Procedure:

- ORTHOTOPIC
- HETEROTOPIC

Procedure Type:

- Whole Liver
- Partial Liver, remainder not Tx or Living Transplant
- Split Liver
- Whole Liver with Pancreas (Technical Reasons)
- Partial Liver with Pancreas (Technical Reasons)
- Split Liver with Pancreas (Technical Reasons)

Split Type:

Preservation Information:

Warm Ischemia Time (include anastomotic time): min ST=

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

Risk Factors:

Did Patient receive 5 or more units of packed red blood cells within 48 hours prior to transplantation due to spontaneous portal hypertensive bleeding: YES NO UNK

Spontaneous Bacterial Peritonitis: YES NO UNK

Previous Abdominal Surgery: * YES NO UNK

Portal Vein Thrombosis: * YES NO UNK

Transjugular Intrahepatic Portacaval Stint Shunt: * YES NO UNK

Incidental Tumor found at time of Transplant: YES NO UNK

If yes, specify tumor type:

- Hepatocellular Adenoma
- Hemangioma
- Hemangioendothelioma
- Angiomyolipoma
- Bile Duct Cystadenocarcinoma
- Cholangiocarcinoma
- Hepatocellular Carcinoma
- Hepatoblastoma
- Angiosarcoma
- Other Primary Liver Tumor, Specify

Specify:

Clinical Information : POST TRANSPLANT

Pathology Conf. Liver Diag. of Hospital Discharge: *

Specify:

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.

Date of Graft Failure:

Causes of graft failure:

Primary Graft Failure	○ YES ○ NO ○ UNK
Vascular Thrombosis	○ YES ○ NO ○ UNK
Biliary Tract Complication	○ YES ○ NO ○ UNK
Hepatitis: DeNovo	○ YES ○ NO ○ UNK
Hepatitis: Recurrent	○ YES ○ NO ○ UNK
Recurrent Disease (non-Hepatitis)	○ YES ○ NO ○ UNK
Acute Rejection	○ YES ○ NO ○ UNK
Infection	○ YES ○ NO ○ UNK
Other, Specify:	

Discharge Lab Date:			
Total Bilirubin:	mg/dl	**ST=**	
SGPT/ALT:	U/L	**ST=**	
Serum Albumin:	g/dl	**ST=**	
Serum Creatinine:	mg/dl	**ST=**	
INR:		**ST=**	

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
- Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

		Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)		☐			☐	☐
Atgam (ATG)		☐			☐	☐
OKT3 (Orthoclone, Muromonab)		☐			☐	☐
Thymoglobulin		☐			☐	☐
Simulect - Basiliximab		☐			☐	☐
Zenapax - Daclizumab		☐			☐	☐
Azathioprine (AZA, Imuran)		☐			☐	☐
EON (Generic Cyclosporine)		☐			☐	☐
Gengraf (Abbott Cyclosporine)		☐			☐	☐
Other generic Cyclosporine, specify brand:		☐			☐	☐
Neoral (CyA-NOF)		☐			☐	☐
Sandimmune (Cyclosporine A)		☐			☐	☐
CellCept (Mycophenolate Mofetil; MMF)		☐			☐	☐
Generic MMF (Generic CellCept)		☐			☐	☐
Prograf (Tacrolimus, FK506)		☐			☐	☐
Generic Tacrolimus (Generic Prograf)		☐			☐	☐
Advagraf (Tacrolimus Extended or Modified Release)		☐			☐	☐
Nulojix (Belatacept)		☐			☐	☐
Sirolimus (RAPA, Rapamycin, Rapamune)		☐			☐	☐
Myfortic (Mycophenolate Sodium)		☐			☐	☐

Other Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR

Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)						
Other Immunosuppressive Medication, Specify						

Records

Adult Intestine Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Secondary Diagnosis:

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant: *	○ IN INTENSIVE CARE UNIT ○ HOSPITALIZED NOT IN ICU ○ NOT HOSPITALIZED
Patient on Life Support: *	○ YES ○ NO
	☐ Ventilator ☐ Artificial Liver ☐ Other Mechanism, Specify
Specify:	
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/ 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
- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Source of Payment:

Primary: *

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

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

Weight: * lbs kg **ST=**

BMI: kg/m^2

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 IgG: *

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

CMV IgM: *

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

- Positive
- Negative

HBV Core Antibody: *

- 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

Total Bilirubin: * _____ mg/dl **ST=** _____

Serum Albumin: * _____ g/dl **ST=** _____

Serum Creatinine: * _____ mg/dl **ST=** _____

Malignancies between listing and transplant: * YES NO UNK

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
- Hepatocellular Carcinoma
- Other, specify

Specify: _____

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

Liver Dysfunction: ○ YES ○ NO ○ UNK

Previous Abdominal Surgery:* ○ YES ○ NO ○ UNK

Number Previous Abdominal Surgeries: _____ ST= _____

Dilated/Non-Functional Bowel Segments:* ○ YES ○ NO ○ UNK

Other: _____

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
- 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

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
- Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)	☐			☐	☐
Atgam (ATG)	☐			☐	☐
OKT3 (Orthoclone, Muromonab)	☐			☐	☐
Thymoglobulin	☐			☐	☐
Simulect - Basiliximab	☐			☐	☐
Zenapax - Daclizumab	☐			☐	☐
Azathioprine (AZA, Imuran)	☐			☐	☐
EON (Generic Cyclosporine)	☐			☐	☐

Gengraf (Abbott Cyclosporine)						
Other generic Cyclosporine, specify brand:						
Neoral (CyA-NOF)						
Sandimmune (Cyclosporine A)						
CellCept (Mycophenolate Mofetil; MMF)						
Generic MMF (Generic CellCept)						
Prograf (Tacrolimus, FK506)						
Generic Tacrolimus (Generic Prograf)						
Advagraf (Tacrolimus Extended or Modified Release)						
Nulojix (Belatacept)						
Sirolimus (RAPA, Rapamycin, Rapamune)						
Myfortic (Mycophenolate Sodium)						

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)						
Other Immunosuppressive Medication, Specify						

Records

Adult Thoracic - Lung Transplant Recipient Registration Worksheet

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Recipient Information

Name: **DOB:**

SSN: **Gender:**

HIC: **Tx Date:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Physician Name: *

Physician NPI#: *

Surgeon Name: *

Surgeon NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant: *
- 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:

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/ 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
- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Source of Payment:

Primary: *

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

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

Weight: * lbs kg **ST=**

BMI: kg/m^2

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 IgG: *

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

CMV IgM: *

- 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

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

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

Previous Pregnancies:

- 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

(which may or may not have resulted in a live birth)

Malignancies between listing and transplant: * YES NO UNK

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:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

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):

Left Lung:	min	**ST=**
Right Lung (OR EN-BLOC):	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

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

Date of Graft Failure:

Primary Cause of Graft Failure:

- Primary Non-Function
- Acute Rejection
- Chronic Rejection/Atherosclerosis
- Other, Specify

Specify:

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

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
- ☐ Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

		Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)		☐			☐	☐
Atgam (ATG)		☐			☐	☐
OKT3 (Orthoclone, Muromonab)		☐			☐	☐
Thymoglobulin		☐			☐	☐
Simulect - Basiliximab		☐			☐	☐
Zenapax - Daclizumab		☐			☐	☐
Azathioprine (AZA, Imuran)		☐			☐	☐
EON (Generic Cyclosporine)		☐			☐	☐
Gengraf (Abbott Cyclosporine)		☐			☐	☐
Other generic Cyclosporine, specify brand:		☐			☐	☐
Neoral (CyA-NOF)		☐			☐	☐
Sandimmune (Cyclosporine A)						

CellCept (Mycophenolate Mofetil; MMF)					
Generic MMF (Generic CellCept)					
Prograf (Tacrolimus, FK506)					
Generic Tacrolimus (Generic Prograf)					
Advagraf (Tacrolimus Extended or Modified Release)					
Nulojix (Belatacept)					
Sirolimus (RAPA, Rapamycin, Rapamune)					
Myfortic (Mycophenolate Sodium)					

Other Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)					
Cyclophosphamide (Cytoxan)					
Leflunomide (LFL, Arava)					
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)					
Other Immunosuppressive Medication, Specify					
Rituximab					

Investigational Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Zortress (Everolimus)					
Other Immunosuppressive Medication, Specify					

Records

Adult Thoracic - Heart/Lung Transplant Recipient Registration Worksheet

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Recipient Information

Name: **DOB:**

SSN: **Gender:**

HIC: **Tx Date:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Physician Name: *

Physician NPI#: *

Surgeon Name: *

Surgeon NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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: *

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/ 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
- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Source of Payment:

Primary:*

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

Height:* ft. in. cm ST=

Weight:* lbs kg ST=

BMI: kg/m^2

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:

- Positive

HIV Serostatus: *	Negative Not Done UNK/Cannot Disclose
CMV IgG: *	Positive Negative Not Done UNK/Cannot Disclose
CMV IgM: *	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

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

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

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

(which may or may not have resulted in a live birth)

Malignancies between listing and transplant: ○ YES ○ NO ○ UNK

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: _____

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

- ○ Heart

Procedure Type: ○ 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= _____

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

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

Date of Graft Failure: _____

Primary Cause of Graft Failure:

- ○ Primary Non-Function
- ○ Acute Rejection
- ○ Chronic Rejection/Atherosclerosis
- ○ Other, Specify

Specify: _____

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 ☐ Valacyclovir (Valtrex)
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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)	☐			☐	☐
Atgam (ATG)	☐			☐	☐
OKT3 (Orthoclone, Muromonab)	☐			☐	☐
Thymoglobulin	☐			☐	☐
Simulect - Basiliximab	☐			☐	☐
Zenapax - Daclizumab	☐			☐	☐
Azathioprine (AZA, Imuran)	☐			☐	☐
EON (Generic Cyclosporine)	☐			☐	☐

Gengraf (Abbott Cyclosporine)						
Other generic Cyclosporine, specify brand:						
Neoral (CyA-NOF)						
Sandimmune (Cyclosporine A)						
CellCept (Mycophenolate Mofetil; MMF)						
Generic MMF (Generic CellCept)						
Prograf (Tacrolimus, FK506)						
Generic Tacrolimus (Generic Prograf)						
Advagraf (Tacrolimus Extended or Modified Release)						
Nulojix (Belatacept)						
Sirolimus (RAPA, Rapamycin, Rapamune)						
Myfortic (Mycophenolate Sodium)						

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)						
Other Immunosuppressive Medication, Specify						

UNOS View Only

Comments:

Records

Pediatric Kidney Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant:*	○ IN INTENSIVE CARE UNIT ○ HOSPITALIZED NOT IN ICU ○ NOT HOSPITALIZED
Functional Status:*	
Cognitive Development:*	○ Definite Cognitive delay/impairment ○ Probable Cognitive delay/impairment ○ Questionable Cognitive delay/impairment ○ No Cognitive delay/impairment ○ 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 < 5 years old/ 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 < 5 years old/ High School graduate or GED ○ Status Unknown
Source of Payment:	
Primary:*	
Specify:	
Secondary:	

Clinical Information : PRETRANSPLANT

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=

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

Viral Detection:

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

CMV IgG: *
- ○ **Positive**
- ○ **Negative**
- ○ **Not Done**
- ○ **UNK/Cannot Disclose**

CMV IgM: *
- ○ **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**

- ○ **Positive**

EBV Serostatus: *

- Negative
- Not Done
- UNK/Cannot Disclose

Was preimplantation kidney biopsy performed at the transplant center: YES NO

Did patient receive any pretransplant blood transfusions: * YES NO UNK

Any tolerance induction technique used: 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

(which may or may not have resulted in a live birth)

Malignancies between listing and transplant: * YES NO UNK

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:

Kidney Preservation Information:

Total Cold ischemia Time Right KI(OR EN-BLOC): (if pumped, include pump time):	hrs	**ST=**
Total Warm Ischemia Time Right KI (OR EN-BLOC): (Include Anastomotic time):	min	**ST=**
Total Cold ischemia Time Left KI (if pumped, include pump time):	hrs	**ST=**
Total Warm ischemia Time Left KI (include Anastomotic time):	min	**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:

Final resistance at transplant: ST=

Final flow rate at transplant: ST=

Incidental Tumor found at time of Transplant: ○ **YES** ○ **NO** ○ **UNK**

If yes, specify tumor type:
- ○ **Oncocytoma**
- ○ **Renal Cell Carcinoma**
- ○ **Carcinoid**
- ○ **Adenoma**
- ○ **Transitional Cell Carcinoma**

Other Primary Kidney Tumor, Specify.

Specify:

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.

Resumed Maintenance Dialysis: YES NO

Date Maintenance Dialysis Resumed:

Select a Dialysis Provider:

Provider #:

Provider Name:

Date of Graft Failure:

Primary Cause of Graft Failure:
- HYPERACUTE REJECTION
- ACUTE REJECTION
- PRIMARY FAILURE
- GRAFT THROMBOSIS
- INFECTION
- SURGICAL COMPLICATIONS
- UROLOGICAL COMPLICATIONS
- RECURRENT DISEASE
- OTHER SPECIFY CAUSE

Specify:

Contributory causes of graft failure:

Acute Rejection: YES NO UNK

Graft Thrombosis: YES NO UNK

Infection: YES NO UNK

Surgical Complications: YES NO UNK

Urological Complications: YES NO UNK

Recurrent Disease: YES NO UNK

Other, Specify:

Most Recent Serum Creatinine Prior to Discharge:* mg/dl **ST=**

Kidney Produced > 40ml of Urine in First 24 Hours: YES NO

Patient Need Dialysis within First Week:* YES NO

Creatinine decline by 25% or more in first 24 hours on 2

separate samples: ○ YES ○ NO

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

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

Date of Measurement:

Height:* ft. in. cm ST=

Weight:* lbs kg ST=

BMI: kg/m^2

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
- ☐ Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)	☐			☐	☐
Atgam (ATG)	☐			☐	☐
OKT3 (Orthoclone, Muromonab)	☐			☐	☐
Thymoglobulin	☐			☐	☐
Simulect - Basiliximab	☐			☐	☐
Zenapax - Daclizumab	☐			☐	☐
Azathioprine (AZA, Imuran)	☐			☐	☐
EON (Generic Cyclosporine)	☐			☐	☐
Gengraf (Abbott Cyclosporine)	☐			☐	☐

Other generic Cyclosporine, specify brand:						
Neoral (CyA-NOF)						
Sandimmune (Cyclosporine A)						
CellCept (Mycophenolate Mofetil; MMF)						
Generic MMF (Generic CellCept)						
Prograf (Tacrolimus, FK506)						
Generic Tacrolimus (Generic Prograf)						
Advagraf (Tacrolimus Extended or Modified Release)						
Nulojix (Belatacept)						
Sirolimus (RAPA, Rapamycin, Rapamune)						
Myfortic (Mycophenolate Sodium)						

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)						
Other Immunosuppressive Medication, Specify						

UNOS View Only

Comments:

Records

Pediatric Kidney-Pancreas Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Kidney Primary Diagnosis: *

Specify:

Pancreas Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Retransplanted organ: Kidney Pancreas Kidney/Pancreas

Primary Cause of Death:

Specify:

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

Functional Status: *

Cognitive Development: *

- Definite Cognitive delay/impairment
- Probable Cognitive delay/impairment
- Questionable Cognitive delay/impairment
- No Cognitive delay/impairment
- 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 < 5 years old/ 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 < 5 years old/ High School graduate or GED
- Status Unknown

Kidney Source of Payment:

Primary: *

Specify:

Secondary:

Pancreas Source of Payment:

Primary:

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

Date of Measurement:

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

Weight: kg **ST=**

BMI: kg/m^2

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: **ST=**

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

Viral Detection:

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

CMV IgG: **Positive** **Negative** **Not Done** **UNK/Cannot Disclose**

CMV IgM: **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
Was preimplantation kidney biopsy performed at the transplant center:	○ YES ○ NO
Did patient receive any pretransplant blood tranfusions: *	○ YES ○ NO ○ UNK
Any tolerance induction technique used:	○ YES ○ NO ○ UNK
Previous Pregnancies: (which may or may not have resulted in a live birth)	○ 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
This question is NOT applicable for patients receiving living donor transplants who were never on the waiting list.	
	☐ Skin Melanoma

If yes, specify type:

- ☐ 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:

Was the Pancreas revascularized before or after other organs:

- ○ Before
- ○ Simultaneous
- ○ After
- ○ Not Applicable

Surgical Incision:

- ○ Iliac Fossa PA left/KI right
- ○ Iliac Fossa PA right/KI left
- ○ Left
- ○ Midline
- ○ Right

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 Warm Ischemia Time Right KI (OR EN-BLOC): (Include Anastomotic time):	min	ST=
Total Cold Ischemia Time Left KI (If pumped, include pump time):	hrs	ST=
Total Warm ischemia Time Left KI (Include Anastomotic time):	min	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:

Final resistance at transplant: ST=

Final flow rate at transplant: ST=

Incidental Tumor found at time of Transplant: YES NO UNK

If yes, specify tumor type:
- Oncocytoma
- Renal Cell Carcinoma
- Carcinoid
- Adenoma
- Transitional Cell Carcinoma
- Other Primary Kidney Tumor, Specify.

Specify:

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:

Select a Dialysis Provider:

Provider #:

Provider Name:

Kidney Date of Graft Failure:

Kidney Primary Cause of Graft Failure:
- HYPERACUTE REJECTION
- ACUTE REJECTION
- PRIMARY FAILURE
- GRAFT THROMBOSIS
- INFECTION
- SURGICAL COMPLICATIONS
- UROLOGICAL COMPLICATIONS
- RECURRENT DISEASE
- OTHER SPECIFY CAUSE

Specify:

Contributory causes of graft failure:

Kidney Acute Rejection:	YES NO UNK
Kidney Graft Thrombosis:	YES NO UNK
Kidney Infection:	YES NO UNK
Surgical Complications:	YES NO UNK
Urological Complications:	YES NO UNK
Recurrent Disease:	YES NO UNK
Other, 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
Was biopsy done to confirm acute rejection:	Biopsy not done Yes, rejection confirmed Yes, rejection not confirmed

Is growth hormone therapy used between listing and transplant:*	YES NO UNK
Most Recent Serum Creatinine Prior to Discharge:*	mg/dl ST=
Kidney Produced > 40ml of Urine in First 24 Hours:	YES NO
Patient Need Dialysis within First Week:*	YES NO
Creatinine Decline by 25% or More in First 24 Hours on 2 separate samples:	YES NO

Pancreas Graft Status:* Functioning Partial Function Failed

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

Method of blood sugar control: (check all that apply)	Insulin Oral medication Diet No Treatment
Date Insulin/Medication Resumed:	
Date of Graft Failure Pancreas:	
Pancreas Graft Removed:	YES NO UNK
If Yes, Date Pancreas Graft Removed:	

Pancreas Primary Cause of Graft Failure:

Pancreas Primary Cause of Graft Failure/Specify:

Contributory causes of graft failure:

Pancreas Graft/Vascular Thrombosis: YES NO UNK

Pancreas Infection: YES NO UNK

Bleeding: YES NO UNK

Anastomotic Leak: YES NO UNK

Hyperacute Rejection: YES NO UNK

Pancreas Acute Rejection: YES NO UNK

Biopsy Proven Isletitis: YES NO UNK

Pancreatitis: YES NO UNK

Other, Specify:

Did patient have any acute pancreas 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

Pancreas Transplant Complications:

(Not leading to graft failure.)

Pancreatitis:* YES NO UNK

Anastomotic Leak:* YES NO UNK

Abcess or Local Infection:* YES NO UNK

Other:

Weight Post Transplant:* lbs. kg ST=

Treatment

Biological or Anti-viral Therapy: YES NO Unknown/Cannot disclose

- Acyclovir (Zovirax)

If Yes, check all that apply:

- 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
- Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

		Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)		☐			☐	☐
Atgam (ATG)		☐			☐	☐
OKT3 (Orthoclone, Muromonab)		☐			☐	☐
Thymoglobulin		☐			☐	☐
Simulect - Basiliximab		☐			☐	☐
Zenapax - Daclizumab		☐			☐	☐
Azathioprine (AZA, Imuran)		☐			☐	☐
EON (Generic Cyclosporine)		☐			☐	☐
Gengraf (Abbott Cyclosporine)		☐			☐	☐
Other generic Cyclosporine, specify brand:		☐			☐	☐
Neoral (CyA-NOF)		☐			☐	☐
Sandimmune (Cyclosporine A)		☐			☐	☐
CellCept (Mycophenolate Mofetil; MMF)		☐			☐	☐
Generic MMF (Generic CellCept)		☐			☐	☐
Prograf (Tacrolimus, FK506)		☐			☐	☐
Generic Tacrolimus (Generic Prograf)		☐			☐	☐
Advagraf (Tacrolimus Extended or Modified Release)		☐			☐	☐
Nulojix (Belatacept)		☐			☐	☐
Sirolimus (RAPA, Rapamycin, Rapamune)		☐			☐	☐
Myfortic (Mycophenolate Sodium)		☐			☐	☐

Other Immunosuppressive Medications

Ind.	Days	ST	Maint	AR

Campath - Alemtuzumab (anti-CD52)		☐			☐	☐
Cyclophosphamide (Cytoxan)		☐			☐	☐
Leflunomide (LFL, Arava)		☐			☐	☐
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)		☐			☐	☐
Other Immunosuppressive Medication, Specify		☐			☐	☐
Rituximab		☐			☐	☐

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)		☐			☐	☐
Other Immunosuppressive Medication, Specify		☐			☐	☐

UNOS View Only

Comments:

Records

Pediatric Pancreas Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant:*	IN INTENSIVE CARE UNIT HOSPITALIZED NOT IN ICU NOT HOSPITALIZED
Functional Status:*	
Cognitive Development:*	Definite Cognitive delay/impairment Probable Cognitive delay/impairment Questionable Cognitive delay/impairment No Cognitive delay/impairment 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 < 5 years old/ 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 Not Applicable < 5 years old/ High School graduate or GED Status Unknown
Source of Payment:	
Primary:*	
Specify:	
Secondary:	

Clinical Information : PRETRANSPLANT

Date of Measurement:	

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

Weight: lbs kg **ST=**

BMI: kg/m^2

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: **ST=**

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

Viral Detection:

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

CMV IgG:
- **Positive**
- **Negative**
- **Not Done**
- **UNK/Cannot Disclose**

CMV IgM:
- **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**

- **Positive**
- **Negative**

HCV Serostatus:
- Not Done
- UNK/Cannot Disclose

EBV Serostatus:
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

Malignancies between listing and transplant: YES NO UNK

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:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Procedure Type:

Surgical Information:

If a simultaneous Tx with another organ, was the Pancreas revascularized before or after other organs:
- Before
- Simultaneous
- After
- Not Applicable

Surgical Incision:
- Left
- Midline
- Other

	○ Right
Graft Placement:*	○ INTRA-PERITONEAL ○ RETRO-PERITONEAL ○ PARTIAL INTRA/RETRO-PERITONEAL
Operative Technique:*	○ PANCREAS ALONE ○ CLUSTER ○ MULTI-ORGAN NON-CLUSTER ○ PANCREAS AFTER KIDNEY ○ PANCREAS WITH KIDNEY DIFFERENT DONOR
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

Preservation Information:

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

Clinical Information : POST TRANSPLANT

Pancreas Graft Status:* ○ Functioning ○ Partial Function ○ Failed

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

☐ Insulin

Method of blood sugar control: (check all that apply)

- ☐ Oral medication
- ☐ Diet
- ☐ No Treatment

Date insulin/medication first resumed:

Date of Graft Failure:

Pancreas Graft Removed: ○ YES ○ NO ○ UNK

Date Pancreas Graft Removed:

Pancreas Primary Cause of Graft Failure:

Specify:

Contributory causes of graft failure:

Pancreas Graft/Vascular Thrombosis: ○ YES ○ NO ○ UNK

Pancreas Infection: ○ YES ○ NO ○ UNK

Bleeding: ○ YES ○ NO ○ UNK

Anastomotic Leak: ○ YES ○ NO ○ UNK

Hyperacute Rejection: ○ YES ○ NO ○ UNK

Pancreas Acute Rejection: ○ YES ○ NO ○ UNK

Biopsy Proven Isletitis: ○ YES ○ NO ○ UNK

Pancreatitis: ○ YES ○ NO ○ UNK

Other, Specify:

Pancreas Transplant Complications:
(Not leading to graft failure.)

Pancreatitis:* ○ YES ○ NO ○ UNK

Anastomotic Leak:* ○ YES ○ NO ○ UNK

Abcess or Local Infection:* ○ YES ○ NO ○ UNK

Pancreas Transplant Complications: Other

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
- Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

		Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)		☐			☐	☐
Atgam (ATG)		☐			☐	☐
OKT3 (Orthoclone, Muromonab)		☐			☐	☐
Thymoglobulin		☐			☐	☐
Simulect - Basiliximab		☐			☐	☐
Zenapax - Daclizumab		☐			☐	☐
Azathioprine (AZA, Imuran)		☐			☐	☐
EON (Generic Cyclosporine)		☐			☐	☐
Gengraf (Abbott Cyclosporine)		☐			☐	☐
Other generic Cyclosporine, specify brand:		☐			☐	☐
Neoral (CyA-NOF)		☐			☐	☐
Sandimmune (Cyclosporine A)		☐			☐	☐
CellCept (Mycophenolate Mofetil; MMF)		☐			☐	☐
Generic MMF (Generic CellCept)		☐			☐	☐
Prograf (Tacrolimus, FK506)		☐			☐	☐
Generic Tacrolimus (Generic Prograf)		☐			☐	☐
Advagraf (Tacrolimus Extended or Modified Release)		☐			☐	☐
Nulojix (Belatacept)		☐			☐	☐

Sirolimus (RAPA, Rapamycin, Rapamune)	☐			☐	☐
Myfortic (Mycophenolate Sodium)	☐			☐	☐

Other Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)	☐			☐	☐
Cyclophosphamide (Cytoxan)	☐			☐	☐
Leflunomide (LFL, Arava)	☐			☐	☐
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	☐			☐	☐
Other Immunosuppressive Medication, Specify	☐			☐	☐
Rituximab	☐			☐	☐

Investigational Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Zortress (Everolimus)	☐			☐	☐
Other Immunosuppressive Medication, Specify	☐			☐	☐

UNOS View Only

Comments:

Records

Pediatric Liver Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant:*	○ IN INTENSIVE CARE UNIT ○ HOSPITALIZED NOT IN ICU ○ NOT HOSPITALIZED
Patient on Life Support:*	○ YES ○ NO ☐ Ventilator ☐ Artificial Liver ☐ Other Mechanism, Specify Specify:
Functional Status:*	
Cognitive Development:*	○ Definite Cognitive delay/impairment ○ Probable Cognitive delay/impairment ○ Questionable Cognitive delay/impairment ○ No Cognitive delay/impairment ○ 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 < 5 years old/ 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 ○ Not Applicable < 5 years old/ High School graduate or GED ○ Status Unknown

Source of Payment:

Primary: *

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

Date of Measurement:

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

Weight: * lbs kg **ST=**

BMI: kg/m^2

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 IgG: *
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

CMV IgM: *
- 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

Any tolerance induction technique used: YES NO UNK

Pretransplant Lab Date:

SGPT/ALT: U/L **ST=**

Malignancies between listing and transplant: * YES NO UNK

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
- Hepatoblastoma
- Hepatocellular Carcinoma
- Other, specify

Specify:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

Surgical Procedure:

- ORTHOTOPIC

	HETEROTOPIC
Procedure Type:	Whole Liver Partial Liver, remainder not Tx or Living Transplant Split Liver Whole Liver with Pancreas (Technical Reasons) Partial Liver with Pancreas (Technical Reasons) Split Liver with Pancreas (Technical Reasons)
Split Type:	

Preservation Information:

Warm Ischemia Time (include anastomotic time):	min	ST=
Total Cold Ischemia Time (if pumped, include pump time): *	hrs	ST=

Risk Factors:

Did Patient receive 5 or more units of packed red blood cells within 48 hours prior to transplantation due to spontaneous portal hypertensive bleeding:	YES NO UNK
Spontaneous Bacterial Peritonitis:	YES NO UNK
Previous Abdominal Surgery: *	YES NO UNK
Portal Vein Thrombosis: *	YES NO UNK
Transjugular Intrahepatic Portacaval Stint Shunt: *	YES NO UNK

Incidental Tumor found at time of Transplant:	YES NO UNK
If yes, specify tumor type:	Hepatocellular Adenoma Hemangioma Hemangioendothelioma Angiomyolipoma Bile Duct Cystadenocarcinoma Cholangiocarcinoma Hepatocellular Carcinoma Hepatoblastoma Angiosarcoma Other Primary Liver Tumor, Specify
Specify:	

Clinical Information : POST TRANSPLANT

Pathology Conf. Liver Diag. of Hospital Discharge: *	

Specify:

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.

Date of Graft Failure:

Causes of graft failure:

Primary Graft Failure	○ YES ○ NO ○ UNK
Vascular Thrombosis	○ YES ○ NO ○ UNK
Hepatic arterial thrombosis:	○ YES ○ NO ○ UNK
Hepatic outflow obstruction:	○ YES ○ NO ○ UNK
Portal vein thrombosis:	○ YES ○ NO ○ UNK
Biliary Tract Complication	○ YES ○ NO ○ UNK
Hepatitis: DeNovo	○ YES ○ NO ○ UNK
Hepatitis: Recurrent	○ YES ○ NO ○ UNK
Recurrent Disease (non-Hepatitis)	○ YES ○ NO ○ UNK
Acute Rejection	○ YES ○ NO ○ UNK
Infection	○ YES ○ NO ○ UNK
Other, Specify:	

Discharge Lab Date:			
Total Bilirubin:		mg/dl	**ST=**
SGPT/ALT:		U/L	**ST=**
Serum Albumin:		g/dl	**ST=**
Serum Creatinine:		mg/dl	**ST=**
INR:			**ST=**

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
- ☐ Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

		Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)		☐			☐	☐
Atgam (ATG)		☐			☐	☐
OKT3 (Orthoclone, Muromonab)		☐			☐	☐
Thymoglobulin		☐			☐	☐
Simulect - Basiliximab		☐			☐	☐
Zenapax - Daclizumab		☐			☐	☐
Azathioprine (AZA, Imuran)		☐			☐	☐
EON (Generic Cyclosporine)		☐			☐	☐
Gengraf (Abbott Cyclosporine)		☐			☐	☐
Other generic Cyclosporine, specify brand:		☐			☐	☐
Neoral (CyA-NOF)		☐			☐	☐
Sandimmune (Cyclosporine A)		☐			☐	☐
CellCept (Mycophenolate Mofetil; MMF)		☐			☐	☐
Generic MMF (Generic CellCept)		☐			☐	☐
Prograf (Tacrolimus, FK506)		☐			☐	☐
Generic Tacrolimus (Generic Prograf)		☐			☐	☐
Advagraf (Tacrolimus Extended or Modified Release)		☐			☐	☐
Nulojix (Belatacept)		☐			☐	☐
Sirolimus (RAPA, Rapamycin, Rapamune)		☐			☐	☐
Myfortic (Mycophenolate Sodium)		☐			☐	☐

Other Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)	☐			☐	☐
Cyclophosphamide (Cytoxan)	☐			☐	☐
Leflunomide (LFL, Arava)	☐			☐	☐
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	☐			☐	☐
Other Immunosuppressive Medication, Specify	☐			☐	☐
Rituximab	☐			☐	☐

Investigational Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Zortress (Everolimus)	☐			☐	☐
Other Immunosuppressive Medication, Specify	☐			☐	☐

UNOS View Only

Comments:

Records

Pediatric Intestine Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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Recipient Information

Name: **DOB:**

SSN: **Gender:**

HIC: **Tx Date:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Surgeon Name: *

NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Secondary Diagnosis:

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant: *	○ IN INTENSIVE CARE UNIT ○ HOSPITALIZED NOT IN ICU ○ NOT HOSPITALIZED
Patient on Life Support: *	○ YES ○ NO
	☐ Ventilator ☐ Artificial Liver ☐ Other Mechanism, Specify
Specify:	
Functional Status: *	
Cognitive Development: *	○ Definite Cognitive delay/impairment ○ Probable Cognitive delay/impairment ○ Questionable Cognitive delay/impairment ○ No Cognitive delay/impairment ○ 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 < 5 years old/ 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

- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Source of Payment:

Primary: *

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

Date of Measurement:

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

Weight: * lbs kg **ST=**

BMI: kg/m^2

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 IgG: *
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

CMV IgM: *
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

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

- Positive

HBV Surface Antigen:*

- Negative
- Not Done
- UNK/Cannot Disclose

HCV Serostatus:*

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

EBV Serostatus:*

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

Total Bilirubin:* mg/dl ST=

Serum Albumin:* g/dl ST=

Serum Creatinine:* mg/dl ST=

Malignancies between listing and transplant:* YES NO UNK

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
- Hepatoblastoma
- Hepatocellular Carcinoma
- Other, specify

Specify:

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

Liver Dysfunction: ○ YES ○ NO ○ UNK

Previous Abdominal Surgery:* ○ YES ○ NO ○ UNK

Number Previous Abdominal Surgeries: _____ ST= _____

Dilated/Non-Functional Bowel Segments:* ○ YES ○ NO ○ UNK

Other: _____

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
- GVHD (Graft Versus Host Disease)
- Ischemia/NEC (Necrotizing Enterocolitis) 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

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
- Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)					
Atgam (ATG)					
OKT3 (Orthoclone, Muromonab)					
Thymoglobulin					
Simulect - Basiliximab					
Zenapax - Daclizumab					
Azathioprine (AZA, Imuran)					
EON (Generic Cyclosporine)					

Gengraf (Abbott Cyclosporine)						
Other generic Cyclosporine, specify brand:						
Neoral (CyA-NOF)						
Sandimmune (Cyclosporine A)						
CellCept (Mycophenolate Mofetil; MMF)						
Generic MMF (Generic CellCept)						
Prograf (Tacrolimus, FK506)						
Generic Tacrolimus (Generic Prograf)						
Advagraf (Tacrolimus Extended or Modified Release)						
Nulojix (Belatacept)						
Sirolimus (RAPA, Rapamycin, Rapamune)						
Myfortic (Mycophenolate Sodium)						

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)						
Other Immunosuppressive Medication, Specify						

UNOS View Only

Comments:

Records

Pediatric Thoracic - Lung Transplant Recipient Registration Worksheet

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Recipient Information

Name: **DOB:**

SSN: **Gender:**

HIC: **Tx Date:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Physician Name: *

Physician NPI#: *

Surgeon Name: *

Surgeon NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant: *

- ○ 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
- ☐ Intravenous Inotropes
- ☐ Inhaled NO
- ☐ Ventilator
- ☐ Other Mechanism

Specify:

Functional Status: *

Cognitive Development: *

- ○ Definite Cognitive delay/impairment
- ○ Probable Cognitive delay/impairment
- ○ Questionable Cognitive delay/impairment
- ○ No Cognitive delay/impairment
- ○ 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 < 5 years old/ 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
- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Source of Payment:

Primary:*

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

Date of Measurement:

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

Weight:* lbs kg **ST=**

BMI: kg/m^2

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 IgG:*

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

CMV IgM:*

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

- Positive

HBV Core Antibody: *
- 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

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
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
Prior Thoracic Surgery other than prior transplant:	YES NO UNK
If yes, number of prior sternotomies:	Unknown if there were prior sternotomies 0 1 2 3 4 5+ Unknown number of prior sternotomies
If yes, number of prior thoracotomies:	Unknown if there were prior thoracotomies 0 1 2 3 4 5+ Unknown number of prior thoracotomies
Prior congenital cardiac surgery:	YES NO UNK
If yes, palliative surgery:	YES NO UNK
If yes, corrective surgery:	YES NO UNK
If yes, single ventricular physiology:	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

(which may or may not have resulted in a live birth)

Malignancies between listing and transplant: YES NO UNK

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:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

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):

Left Lung: _____ min ST= _____

Right Lung (OR EN-BLOC): _____ 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

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

Date of Graft Failure: _____

Primary Cause of Graft Failure:
- ○ Primary Non-Function
- ○ Acute Rejection
- ○ Chronic Rejection/Atherosclerosis
- ○ Other, Specify

Specify: _____

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

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
- Valacyclovir (Valtrex)

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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)	☐			☐	☐
Atgam (ATG)	☐			☐	☐
OKT3 (Orthoclone, Muromonab)	☐			☐	☐
Thymoglobulin	☐			☐	☐
Simulect - Basiliximab	☐			☐	☐
Zenapax - Daclizumab	☐			☐	☐
Azathioprine (AZA, Imuran)	☐			☐	☐
EON (Generic Cyclosporine)	☐			☐	☐
Gengraf (Abbott Cyclosporine)	☐			☐	☐

Other generic Cyclosporine, specify brand:						
Neoral (CyA-NOF)						
Sandimmune (Cyclosporine A)						
CellCept (Mycophenolate Mofetil; MMF)						
Generic MMF (Generic CellCept)						
Prograf (Tacrolimus, FK506)						
Generic Tacrolimus (Generic Prograf)						
Advagraf (Tacrolimus Extended or Modified Release)						
Nulojix (Belatacept)						
Sirolimus (RAPA, Rapamycin, Rapamune)						
Myfortic (Mycophenolate Sodium)						

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)						
Other Immunosuppressive Medication, Specify						

Records

Pediatric Thoracic - Heart/Lung Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 03/31/2015

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:**

State of Permanent Residence: *

Permanent Zip: * -

Provider Information

Recipient Center:

Physician Name: *

Physician NPI#: *

Surgeon Name: *

Surgeon NPI#: *

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

Primary Diagnosis: *

Specify:

Date: Last Seen, Retransplanted or Death *

Patient Status: *

- LIVING
- DEAD
- RETRANSPLANTED

Primary Cause of Death:

Specify:

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 at time of transplant: *

○ 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
☐ Intravenous Inotropes
☐ 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: *

Cognitive Development: *

○ Definite Cognitive delay/impairment
○ Probable Cognitive delay/impairment
○ Questionable Cognitive delay/impairment
○ No Cognitive delay/impairment
○ 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 < 5 years old/ 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
- Not Applicable < 5 years old/ High School graduate or GED
- Status Unknown

Source of Payment:

Primary: *

Specify:

Secondary:

Clinical Information : PRETRANSPLANT

Date of Measurement:

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

Weight: * lbs kg **ST=**

BMI: kg/m^2

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 IgG:*
- Positive
- Negative
- Not Done
- UNK/Cannot Disclose

CMV IgM:*
- 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

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

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

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

Prior Thoracic Surgery other than prior transplant: YES NO UNK

If yes, number of prior sternotomies:

- Unknown if there were prior sternotomies
- 0
- 1
- 2
- 3
- 4
- 5+
- Unknown number of prior sternotomies

If yes, number of prior thoracotomies:

- Unknown if there were prior thoracotomies
- 0
- 1
- 2
- 3

- 4
- 5+
- Unknown number of prior thoracotomies

Prior congenital cardiac surgery: YES NO UNK

If yes, palliative surgery: YES NO UNK

If yes, corrective surgery: YES NO UNK

If yes, single ventricular physiology: 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

(which may or may not have resulted in a live birth)

Malignancies between listing and transplant: YES NO UNK

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:

Clinical Information : TRANSPLANT PROCEDURE

Multiple Organ Recipient

Were extra vessels used in the transplant procedure:

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= _____

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

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

Date of Graft Failure: _____

Primary Cause of Graft Failure:
- Primary Non-Function
- Acute Rejection
- Chronic Rejection/Atherosclerosis
- Other, Specify

Specify: _____

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 ☐ Valacyclovir (Valtrex)
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 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, Atgam, Thymoglobulin, OKT3, Simulect, or Zenapax). Some of these drugs might be used for another finite period for rejection therapy and would be recorded as 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 or Zenapax 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 *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, 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, 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.

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.**

	Ind.	Days	ST	Maint	AR
Steroids (Prednisone,Methylprednisolone,Solumedrol,Medrol,Decadron)	☐			☐	☐
Atgam (ATG)	☐			☐	☐
OKT3 (Orthoclone, Muromonab)	☐			☐	☐
Thymoglobulin	☐			☐	☐
Simulect - Basiliximab	☐			☐	☐
Zenapax - Daclizumab	☐			☐	☐
Azathioprine (AZA, Imuran)	☐			☐	☐

EON (Generic Cyclosporine)						
Gengraf (Abbott Cyclosporine)						
Other generic Cyclosporine, specify brand:						
Neoral (CyA-NOF)						
Sandimmune (Cyclosporine A)						
CellCept (Mycophenolate Mofetil; MMF)						
Generic MMF (Generic CellCept)						
Prograf (Tacrolimus, FK506)						
Generic Tacrolimus (Generic Prograf)						
Advagraf (Tacrolimus Extended or Modified Release)						
Nulojix (Belatacept)						
Sirolimus (RAPA, Rapamycin, Rapamune)						
Myfortic (Mycophenolate Sodium)						

Other Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Campath - Alemtuzumab (anti-CD52)						
Cyclophosphamide (Cytoxan)						
Leflunomide (LFL, Arava)						
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)						
Other Immunosuppressive Medication, Specify						
Rituximab						

Investigational Immunosuppressive Medications

		Ind.	Days	ST	Maint	AR
Zortress (Everolimus)						
Other Immunosuppressive Medication, Specify						