

Records

Adult Kidney Transplant Recipient Registration Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 08/31/2007

Note: These worksheets are provided to function as a guide to what data will be required in the online TIEDI^B 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^B 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: *	<input type="text"/>
Permanent Zip: *	<input type="text"/> - <input type="text"/>

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

Donor Information	
UNOS Donor ID #:	
Donor Type:	

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

Transplant Hospitalization:

Date of Admission to Tx Center: *

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
 Status Unknown

- Full academic load

Academic Activity Level:

- Reduced academic load
- Unable to participate in academics due to disease or condition
- Not Applicable < 5 years old/ High School graduate
- 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 First Dialyzed: 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

HBV Surface Antigen: *

- Not Done
- UNK/Cannot Disclose
- 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

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 %ile ST=

Weight:* lbs kg %ile ST=

BMI: kg/m² %ile

Treatment

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

- Acyclovir (Zovirax)
- Cytogam (CMV)
- Gamimune
- Gammagard
- Ganciclovir (Cytovene)
- Valgancyclovir (Valcyte)
- HBIG (Hepatitis B Immune Globulin)
- Flu Vaccine (Influenza Virus)

If Yes, check all that apply:

Lamivudine (Epivir) (for treatment of Hepatitis B)

Other, Specify

Valacyclovir (Valtrex)

Specify:

Specify:

Other therapies:

YES NO

Photopheresis

If Yes, check all that apply:

Plasmapheresis

Total Lymphoid Irradiation (TLI)

Immunosuppressive Information

Are any medications given currently for maintenance or anti-rejection:*

YES NO

Did the patient participate in any clinical research protocol for immunosuppressive medications:

YES NO

If Yes, Specify:

Immunosuppressive Medications

View Immunosuppressive Medications

Definitions Of Immunosuppressive Medications

For each of the 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
Steroids (Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Atgam (ATG)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
OKT3 (Orthoclone, Muromonab)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Thymoglobulin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Simulect - Basiliximab	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Zenapax - Daclizumab	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Azathioprine (AZA, Imuran)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
EON (Generic Cyclosporine)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Gengraf (Abbott Cyclosporine)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other generic Cyclosporine, specify brand:		<input type="text"/>	<input checked="" type="checkbox"/> <input type="text"/>
Neoral (CyA-NOF)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Sandimmune (Cyclosporine A)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Mycophenolate Mofetil (MMF, Cellcept, RS61443)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Tacrolimus (Prograf, FK506)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Modified Release Tacrolimus FK506E (MR4)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Sirolimus (RAPA, Rapamycin, Rapamune)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Myfortic (Mycophenolate Sodium)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>

Other Immunosuppressive Medications				
	Ind.	Days	ST	Maint AR
Campath - Alemtuzumab (anti-CD52)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>
Cyclophosphamide (Cytoxan)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>
Leflunomide (LFL, Arava)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input checked="" type="checkbox"/>
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input checked="" type="checkbox"/> <input type="checkbox"/>
Other Immunosuppressive Medication, Specify <input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> <input type="checkbox"/>

Other Immunosuppressive Medication, Specify

Rituximab

Investigational Immunosuppressive Medications

	Ind.	Days	ST	Maint	AR
Everolimus (RAD, Certican)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
FTY 720	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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Comments: