

## Records

### Adult Kidney-Pancreas Transplant Recipient Follow-Up Worksheet

The revised worksheet sample is for reference purposes only and is pending OMB approval.

Note: These worksheets are provided to function as a guide to what data will be required in the online TIEDI<sup>B</sup> 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<sup>B</sup> 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:
Previous Follow-Up:	Previous Px Stat Date:
Transplant Discharge Date:	<input type="text"/>
State of Permanent Residence: *	<input type="text"/>
Zip Code: *	<input type="text"/> - <input type="text"/>
Provider Information	
Recipient Center:	
Followup Center:	
Physician Name: *	<input type="text"/>
NPI: *	<input type="text"/>
Follow-up Care Provided By: *	<input type="radio"/> Transplant Center <input type="radio"/> Non Transplant Center Specialty Physician <input type="radio"/> Primary Care Physician <input type="radio"/> Other Specify
Specify:	<input type="text"/>
Donor Information	
UNOS Donor ID #:	
Donor Type:	
Patient Status	
Date: Last Seen, Retransplanted or Death *	<input type="text"/>
Patient Status: *	<input type="radio"/> LIVING <input type="radio"/> DEAD <input type="radio"/> RETRANSPLANTED
If Retransplanted, choose organ(s):	<input type="radio"/> Kidney <input type="radio"/> Pancreas <input type="radio"/> Kidney/Pancreas
Primary Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Contributory Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Contributory Cause of Death:	<input type="text"/>
Specify:	<input type="text"/>
Hospitalizations:	
Has the patient been hospitalized since the last patient status date: *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Number of Hospitalizations:	<input type="text"/> St= <input type="text"/>
Noncompliance:	
Was there evidence of noncompliance with immunosuppression medication during this follow-up period that compromised the patient's recovery:	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Functional Status: *	<input type="text"/>
	<input type="radio"/> No Limitations

Physical Capacity:

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

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  
 Status Unknown

Primary Insurance at Follow-up: \*

Specify:

**Clinical Information**

Height:  ft.  in.  cm %ile St=

Weight: \*  lbs.  kg %ile St=

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

Urine Protein Found By Any Method:  YES  NO  UNK

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.

If Functioning, Most Recent Serum Creatinine:  mg/dl St=

Kidney Date of Failure:

Kidney Primary Cause of Graft Failure:

Specify

Contributory causes of graft failure:

Kidney Acute Rejection  YES  NO  UNK  
 Kidney Chronic Rejection  YES  NO  UNK  
 Kidney Graft Thrombosis  YES  NO  UNK  
 Kidney Infection  YES  NO  UNK  
 Urological Complications  YES  NO  UNK

Patient Noncompliance  YES  NO  UNK

Recurrent Disease:  YES  NO  UNK

BK (Polyoma) Virus  YES  NO  UNK

Kidney Other Contributory Cause of Graft Failure

Dialysis Since Last Follow-Up:  NO  
 YES, RESUMED MAINTENANCE DIALYSIS  
 YES, NO MAINTENANCE RESUMPTION  
 YES, MAINTENANCE RESUMPTION UNKNOWN  
 UNKNOWN

Date Maintenance Dialysis Resumed:

Select a Dialysis Provider:

Provider #:

Provider Name:

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:  Insulin  
 Oral medication  
 Diet  
 No Treatment

Date insulin/medication resumed:

Pancreas Date of Failure

Pancreas Graft Removed:  YES  NO  UNK

Date Pancreas Removed:

Pancreas Primary Causes of Graft Failure

Specify:

Contributory causes of graft failure:

Pancreas Graft/Vascular Thrombosis  YES  NO  UNK

Pancreas Infection  YES  NO  UNK

Pancreas Bleeding  YES  NO  UNK

Anastomotic Leak  YES  NO  UNK

Pancreas Rejection: Acute  YES  NO  UNK

Pancreas Chronic Rejection  YES  NO  UNK

Biopsy Proven Isletitis  YES  NO  UNK

Pancreatitis  YES  NO  UNK

Patient Noncompliance  YES  NO  UNK

Other, Specify:

Conv. From Bladder to Enteric Drain Performed:  YES  NO  UNK

Enteric Drain Date:

Serum Amylase:  u/L St=

Pancreas Transplant Complications (Not leading to graft failure):

Pancreatitis  YES  NO  UNK

Anastomotic Leak	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Abcess or Local Infection	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
Other, Specify:	<input type="text"/>

<p>Did patient have any kidney acute rejection episodes during the follow-up period:</p> <p>Was biopsy done to confirm acute rejection:</p>	<input type="radio"/> Yes, at least one episode treated with anti-rejection agent <input type="radio"/> Yes, none treated with additional anti-rejection agent <input type="radio"/> No <input type="radio"/> Unknown  <input type="radio"/> Biopsy not done <input type="radio"/> Yes, rejection confirmed <input type="radio"/> Yes, rejection not confirmed <input type="radio"/> Unknown
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<p>Did patient have any pancreas acute rejection episodes during the follow-up period:</p> <p>Was biopsy done to confirm acute rejection:</p>	<input type="radio"/> Yes, at least one episode treated with anti-rejection agent <input type="radio"/> Yes, none treated with additional anti-rejection agent <input type="radio"/> No <input type="radio"/> Unknown  <input type="radio"/> Biopsy not done <input type="radio"/> Yes, rejection confirmed <input type="radio"/> Yes, rejection not confirmed <input type="radio"/> Unknown
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<p><b>Viral Detection:</b></p> <p>CMV IgG:</p> <p>CMV IgM:</p>	<input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose  <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Not Done <input type="radio"/> UNK/Cannot Disclose
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<p><b>Postrasplant Malignancy:</b>*</p> <p>Donor Related:</p> <p>Recurrence of Pre-Tx Tumor:</p> <p>De Novo Solid Tumor:</p> <p>De Novo Lymphoproliferative disease and Lymphoma:</p>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK  <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK  <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK  <input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
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<p><b>Treatment</b></p> <p>Biological or Anti-viral therapy:</p> <p>If Yes, check all that apply:</p>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> Unknown/Cannot disclose  <input type="checkbox"/> Acyclovir (Zovirax) <input type="checkbox"/> Cytogam (CMV) <input type="checkbox"/> Gamimune <input type="checkbox"/> Gammagard <input type="checkbox"/> Ganciclovir (Cytovene) <input type="checkbox"/> Valgancyclovir (Valcyte) <input type="checkbox"/> HBIG (Hepatitis B Immune Globulin) <input type="checkbox"/> Flu Vaccine (Influenza Virus)
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Lamivudine (Epivir) (for treatment of Hepatitis B)

Valacyclovir (Valtrex)

Other, Specify

Specify:

Specify:

Treatment for BK (polyoma) virus:  YES  NO

Yes, Immunosuppression reduction

Yes, Cidofovir

Yes, IVIG

Yes, Type Unknown

Yes, Other, Specify

If Yes, check all that apply:

Specify:

Other therapies:  YES  NO

Photopheresis

Plasmapheresis

Total Lymphoid Irradiation (TLI)

If Yes, check all that apply:

### Immunosuppressive Information

Previous Validated Maintenance Follow-Up Medications:

Yes, same as previous validated report

Were any medications given during the follow-up period for maintenance:  Yes, but different than previous validated report

None given

Did the physician discontinue all maintenance immunosuppressive medications:  YES  NO

Did the patient participate in any clinical research protocol for immunosuppressive medications:  YES  NO

Specify:

### Immunosuppressive Medications

View Immunosuppressive Medications

#### Definitions Of Immunosuppressive Follow-Up Medications

For each of the immunosuppressant medications listed, check **Previous Maintenance (Prev Maint)**, **Current Maintenance (Curr Maint)** or **Anti-rejection (AR)** to indicate all medications that were prescribed for the recipient during this follow-up period, and for what reason. If a medication was not given, leave the associated box(es) blank.

**Previous Maintenance (Prev Maint)** includes all immunosuppressive medications given during the report period, which covers the period from the last clinic visit to the current clinic visit, *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.

**Current Maintenance (Curr Maint)** includes all immunosuppressive medications given at the current clinic visit to begin in the next report *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.

**Anti-rejection (AR)** immunosuppression includes all immunosuppressive medications given for the purpose of treating an acute rejection episode since the last clinic visit (example: Methylprednisolone, Atgam, OKT3, or Thymoglobulin). When switching maintenance drugs (example: from Tacrolimus to Cyclosporine; or from Mycophenolate Mofetil to Azathioprine) because of rejection, the drugs should not be listed under AR immunosuppression, but should be listed under maintenance immunosuppression.

**Note: The Anti-rejection field refers to any anti-rejection medications since the last clinic visit, not just at the time of the current clinic visit.**

If an immunosuppressive medication other than those listed is being administered (e.g., new monoclonal antibodies), select Previous Maint, or Current Maint, or AR next to Other Immunosuppressive Medication field, and enter the full name of the medication in the space provided. **Do not list non-immunosuppressive medications.**

	Prev Maint	Curr Maint	AR
Steroids (Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atgam (ATG)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
OKT3 (Orthoclone, Muromonab)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Thymoglobulin	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Simulect - Basiliximab	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Zenapax - Daclizumab	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Azathioprine (AZA, Imuran)	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

EON (Generic Cyclosporine)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Gengraf (Abbott Cyclosporine)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Other generic Cyclosporine, specify brand:	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Neoral (CyA-NOF)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sandimmune (Cyclosporine A)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mycophenolate Mofetil (MMF, Cellcept, RS61443)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Tacrolimus (Prograf, FK506)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Modified Release Tacrolimus FK506E (MR4)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Sirolimus (RAPA, Rapamycin, Rapamune)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Myfortic (Mycophenolate Sodium)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

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

Investigational Immunosuppressive Medications				
		Prev Maint	Curr Maint	AR
Everolimus (RAD, Certican)		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
FTY 720		<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

UNOS View Only	
Comments:	<input type="text"/>