Records

Pediatric Kidney Transplant Recipient Follow-Up Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 10/31/2010

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:**

Previous Follow-Up: **Previous Px Stat Date:**

Transplant Discharge Date:

State of Permanent Residence: *

Zip Code: * -

Provider Information

Recipient Center:

Followup Center:

Physician Name: *

NPI#: *

Follow-up Care Provided By: *

- Transplant Center
- Non Transplant Center Specialty Physician
- Primary Care Physician
- Other Specify

Specify:

Donor Information

UNOS Donor ID #:

Donor Type:

Patient Status

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:	
Hospitalizations:	
Has the patient been hospitalized since the last patient status date: *	○ YES ○ NO ○ UNK
Number of Hospitalizations:	**ST=**
TRR Diagnosis:	**Disease Recurrence:** ○ No recurrence ○ Suspected recurrence (not confirmed or unknown is confirmed by biopsy) ○ Biopsy confirmed recurrence ○ Unknown
Noncompliance:	
Was there evidence of noncompliance with immunosuppression medication during this follow-up period that compromised the patient's recovery:	○ YES ○ NO ○ UNK
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
Primary Insurance at Follow-up:*	
Specify:	

Clinical Information

Date of Measurement:				
Height:*	ft.	in.	cm	ST=
Weight:*	lbs.		kg	ST=
BMI:	kg/m^2			

Urine Protein Found By Any Method:	○ YES ○ NO ○ UNK
Diabetes onset during the follow-up period:*	○ YES ○ NO ○ UNK
If yes, insulin dependent:	○ YES ○ NO ○ UNK
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=

Date of Failure:

Primary Cause of Graft Failure:

Other, Specify:

Contributory causes of graft failure:

Acute Rejection	YES	NO	UNK
Chronic Rejection	YES	NO	UNK
Graft Thrombosis	YES	NO	UNK
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

Other, Specify:

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:

- Yes, at least one episode treated with anti-rejection agent

Did patient have any acute rejection episodes during the follow-up period: *	○ **Yes, none treated with additional anti-rejection agent** ○ **No** ○ **Unknown**
Was biopsy done to confirm acute rejection:	○ **Biopsy not done** ○ **Yes, rejection confirmed** ○ **Yes, rejection not confirmed** ○ **Unknown**
Viral Detection:	
CMV IgG:	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**
CMV IgM:	○ **Positive** ○ **Negative** ○ **Not Done** ○ **UNK/Cannot Disclose**
Is growth hormone therapy used during this followup period: *	○ **YES** ○ **NO** ○ **UNK**
Post Transplant Malignancy: *	○ **YES** ○ **NO** ○ **UNK**
Donor Related:	○ **YES** ○ **NO** ○ **UNK**
Recurrence of Pre-Tx Tumor:	○ **YES** ○ **NO** ○ **UNK**
Post Tx De Novo Solid Tumor:	○ **YES** ○ **NO** ○ **UNK**
De Novo Lymphoproliferative disease and Lymphoma:	○ **YES** ○ **NO** ○ **UNK**
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

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)
- ☐ Valacyclovir (Valtrex)
- ☐ Other, Specify

Specify: *

Specify:

Treatment for BK (polyoma) virus:

○ YES ○ NO

If Yes, check all that apply:

- ☐ Yes, Immunosuppression reduction
- ☐ Yes, Cidofovir
- ☐ Yes, IVIG
- ☐ Yes, Type Unknown
- ☐ Yes, Other, Specify

Specify: *

Other therapies: ○ YES ○ NO

If Yes, check all that apply:
- ☐ Photopheresis
- ☐ Plasmapheresis
- ☐ Total Lymphoid Irradiation (TLI)

Immunosuppressive Information

Previous Validated Maintenance Follow-Up Medications:

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Were any medications given during the follow-up period for maintenance:
- ○ Yes, same as validated TRR form
- ○ Yes, same as previous validated report
- ○ 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)		☐	☐	☐
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)		☐	☐	☐
Modified Release Tacrolimus FK506E (MR4)		☐	☐	☐
Sirolimus (RAPA, Rapamycin, Rapamune)		☐	☐	☐
Myfortic (Mycophenolate Sodium)		☐	☐	☐

Other Immunosuppressive Medications

	Prev Maint	Curr 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

		Prev Maint	Curr Maint	AR
Everolimus (RAD, Certican)		☐	☐	☐
Other Immunosuppressive Medication, Specify		☐	☐	☐

UNOS View Only

Comments: