

# Records

## Pediatric Kidney Transplant Recipient Post 5-Year Follow-Up Worksheet

FORM APPROVED: O.M.B. NO. 0915-0157 Expiration Date: 12/31/2011

Note: These worksheets are provided to function as a guide to what data will be required in the online TIEDI<sup>®</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>®</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	
<b>Name:</b>	<b>DOB:</b>
<b>SSN:</b>	<b>Gender:</b>
<b>HIC:</b>	<b>Tx Date:</b>
<b>Previous Follow-Up:</b> Transplant Recipient Registration	<b>Previous Px Stat Date:</b>
<b>Transplant Discharge Date:</b>	<input type="text"/>
<b>State of Permanent Residence:*</b>	<input type="text"/>
<b>Zip Code:*</b>	<input type="text"/> - <input type="text"/>

  

Provider Information	
<b>Recipient Center:</b>	
<b>Followup Center:</b>	

  

Donor Information	
<b>UNOS Donor ID #:</b>	
<b>Donor Type:</b>	

  

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

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

#### Clinical Information

Date of Measurement:

Height:\*

 ft.  in.  cm ST= 

Weight:\*

 lbs.  kg ST= 

BMI:

kg/m<sup>2</sup>

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:

Diabetes onset during the follow-up period:\*

- YES
- NO
- UNK

If yes, insulin dependent:

- YES
- NO
- UNK

Coronary Artery Disease Since Last Follow Up:\*

- YES
- NO
- UNK

<b>Post Transplant Malignancy:</b> *	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>Donor Related:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>Recurrence of Pre-Tx Tumor:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>Post Tx De Novo Solid Tumor:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK
<b>De Novo Lymphoproliferative disease and Lymphoma:</b>	<input type="radio"/> YES <input type="radio"/> NO <input type="radio"/> UNK

<b>UNOS View Only</b>	
<b>Comments:</b>	<div style="border: 1px solid #ccc; height: 60px;"></div>