

# Records

## Adult Kidney-Pancreas Transplant Recipient 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.

Name:

DOB:

SSN:

Gender:

HIC:

Tx Date:

Previous Follow-Up:

Previous Px Stat  
Date:

Transplant Discharge Date:

State of Permanent Residence: \*

Zip Code: \*

Recipient Center:

Followup Center:

Physician Name: \*

NPI#: \*

Transplant Center

Non Transplant Center Specialty Physician

Primary Care Physician

Other Specify

Follow-up Care Provided By: \*

Specify:

UNOS Donor ID #:

Donor Type:

Date: Last Seen, Retransplanted or Death \*

Patient Status: \*

- LIVING
- DEAD
- RETRANSPLANTED

If Retransplanted, choose organ(s):

- Kidney
- Pancreas
- Kidney/Pancreas

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=

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: \*

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

Primary Insurance at Follow-up: \*

Specify:



Height:

 ft.  in.  cm

ST=

Weight: \*

 lbs.  kg

ST=

BMI:

kg/m<sup>2</sup>

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.

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

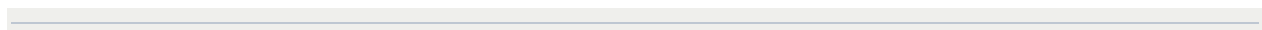
Patient Noncompliance  YES  NO  
 UNK

Recurrent Disease:  YES  NO  
 UNK

BK (Polyoma) Virus  YES  NO  
 UNK

Kidney Other Contributory Cause of Graft Failure

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



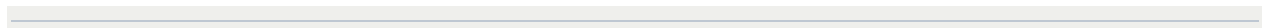
Dialysis Since Last Follow-Up:  NO  
 YES, RESUMED MAINTENANCE DIALYSIS  
 YES, NO MAINTENANCE RESUMPTION  
 YES, MAINTENANCE RESUMPTION UNKNOWN  
 UNKNOWN

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  
 YES  NO  
 UNK  
 YES  NO  
 UNK

Pancreatitis

Patient Noncompliance

Other, Specify:

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

Enteric Drain Date:

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Serum Amylase:  u/L ST=

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Pancreas Transplant Complications (Not leading to graft failure):

YES  NO  UNK  
 YES  NO  UNK  
 YES  NO  UNK

Pancreatitis

Anastomotic Leak

Abcess or Local Infection

Other, Specify:

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Yes, at least one episode treated with anti-rejection agent  
 Yes, none treated with additional anti-rejection agent  
 No  
 Unknown  
 Biopsy not done

Did patient have any kidney acute rejection episodes during the follow-up period:

Yes, rejection confirmed  
 Yes, rejection not confirmed

Was biopsy done to confirm acute rejection:

Unknown

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Did patient have any pancreas acute rejection episodes during the follow-up period:

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

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

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**Viral Detection:**

CMV IgG:

Positive

Negative

Not Done

UNK/Cannot Disclose

CMV IgM:

Positive

Negative

Not Done

UNK/Cannot Disclose

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Post Transplant Malignancy: \*

YES  NO  UNK

Donor Related:

YES  NO  UNK

Recurrence of Pre-Tx Tumor:

YES  NO  UNK



De Novo Solid Tumor:

YES  NO  UNK

De Novo Lymphoproliferative disease and Lymphoma:

YES  NO  UNK

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

Photopheresis

If Yes, check all that apply:

Plasmapheresis

Total Lymphoid Irradiation (TLI)

Previous Validated Maintenance Follow-Up Medications:

Previous Validated Maintenance Follow-Up Medications:

- 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: \*

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.**

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.**

	Prev Maint	Curr Maint	AR
Steroids (Prednisone, Methylprednisolone, Solumedrol, Medrol, Decadron)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atgam (ATG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OKT3 (Orthoclone, Muromonab)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thymoglobulin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Simulect - Basiliximab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Zenapax - Daclizumab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Azathioprine (AZA, Imuran)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EON (Generic Cyclosporine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gengraf (Abbott Cyclosporine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other generic Cyclosporine, specify brand: <input style="width: 100px; height: 15px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neoral (CyA-NOF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Sandimmune (Cyclosporine A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CellCept (Mycophenolate Mofetil; MMF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generic MMF (Generic CellCept)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prograf (Tacrolimus, FK506)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generic Tacrolimus (Generic Prograf)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advagraf (Tacrolimus Extended or Modified Release)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nulojix (Belatacept)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sirolimus (RAPA, Rapamycin, Rapamune)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myfortic (Mycophenolate Sodium)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Prev Maint	Curr Maint	AR
Campath - Alemtuzumab (anti-CD52)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cyclophosphamide (Cytoxan)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leflunomide (LFL, Arava)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methotrexate (Folex, PFS, Mexate-AQ, Rheumatrex)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Immunosuppressive Medication, Specify <input style="width: 100px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rituximab	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Prev Maint	Curr Maint	AR
Zortress (Everolimus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Immunosuppressive Medication, Specify <input style="width: 100px;" type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>