Records

Pediatric Kidney-Pancreas 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
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: *	
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

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

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 YES NO UNK

Abcess or Local Infection YES NO UNK

Other, Specify:

Did patient have any kidney 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

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

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

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:

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: *

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: