Records

Adult Thoracic 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=

Hospitalized for Rejection: YES NO UNK

Hospitalized for Infection: YES NO UNK

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
	○ Full academic load ○ Reduced academic load

Academic Activity Level:

- 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

Height: ft. in. cm ST=

Weight: lbs. kg ST=

BMI: kg/m^2

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.

Date of Graft Failure:

Primary Cause of Graft Failure:

- Primary Non-Function
- Acute Rejection
- Chronic Rejection/Atherosclerosis
- Other, Specify

Other, Specify:

Graft Function:

Lung:

FeV1: * % ST=

O2 Requirement at Rest: * L/min ST=

- NO BOS

Bronchiolitis Obliterans Syndrome:*	○ Yes, Grade OP ○ Yes, Grade 1 ○ Yes, Grade 2 ○ Yes, Grade 3 ○ Yes, Grade UNK ○ Unknown
Bronchial Stricture (Since last follow-up):*	○ YES ○ NO ○ UNK
If yes, Stent:	○ YES ○ NO ○ UNK

Post Transplant Events:	
Drug Treated Hypertension:	○ YES ○ NO ○ UNK
Bone Disease (Symptomatic):	○ YES ○ NO ○ UNK
Chronic Liver Disease:	○ YES ○ NO ○ UNK
Cataracts:	○ YES ○ NO ○ UNK
Diabetes onset during the follow-up period:*	○ YES ○ NO ○ UNK
Diabetes: If Yes, Insulin Dependent:	○ YES ○ NO ○ UNK
Renal Dysfunction:*	○ YES ○ NO ○ UNK
If Yes, Creatinine > 2.5 mg/dl:	○ YES ○ NO ○ UNK
Chronic Dialysis:	○ YES ○ NO ○ UNK
Renal Tx since Thoracic Tx:	○ YES ○ NO ○ UNK
Stroke:	○ YES ○ NO ○ UNK

Drug Treated Hyperlipidemia:	○ YES ○ NO ○ UNK

Did patient have any 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

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

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:

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 Curr AR

		Maint	Maint	
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: