

## **Disease Transmission Event Field Descriptions**

### **Improving Patient Safety:** Potential Donor-derived Disease Transmission Event

The goal of the Improving Patient Safety system is to collect information about safety related incidents occurring system-wide, in order to increase organ utilization and reduce the morbidity and mortality of transplant patients.

### **Disease Transmission Event:**

All events involving unexpected, suspected or proven transmission of a medical condition, including infections and malignancies, discovered after procurement of a donor organ must be reported through the OPTN Patient Safety System.

### **For OPO's:**

OPTN policy specifies when OPOs must report potential disease and malignancy transmission through this portal. OPOs must report the following to the OPTN:

- Results that indicate a disease or condition defined on Pathogens of Special Interest list
- Malignancy or other findings highly suggestive of malignancy recognized post-procurement
- Substantial concerns for donor derived disease or malignancy received from a transplant hospital

OPOs must also report these items within 24 hours, as well as others defined in policy, to transplant hospital patient safety contacts.

### **For Transplant Programs:**

When an organ recipient is suspected to have, is confirmed positive for, or has died from a potential transmissible disease or medical condition for which there is substantial concern that it could be from donor origin, the transplant program must notify the Host OPO by phone and provide available documentation to the Host OPO as soon as possible, and not to exceed 24 hours of this knowledge/concern. The transplant center that suspects potential transmission should not wait for all medical documentation that may eventually be available, but must inform the Host OPO and the OPTN through the "Improving Patient Safety" portal, to transfer this knowledge/concern as soon as possible to all other centers that received organs from the same donor.

### **For Living Donor Recovery Centers:**

When a transmissible disease or medical condition (including malignancy) is recognized in a living donor after organ procurement and relevant to acute patient care (defined as requiring clinical observation, diagnostic testing or therapeutic intervention to diagnose, prevent or treat a potentially transmitted disease), the center must notify the living donor transplant program and submit a report through the OPTN Improving Patient Safety Portal as soon as possible but no later than seven days after receipt of the new information.

Learn more about the required disease transmission event reporting in OPTN/UNOS policy.

Learn more about recent changes to this policy that changed on September 1, 2016

- Policy notice

- Webinar

## Pathogens of Special Interest

To report a potential donor-derived disease transmission event, complete the information below and select the submit button. Please note the incidents are consider confidential and will only be viewable with member and patient identified entered by the user that initially submitted the information and UNOS staff.

### Event Information

**Reporting Event for:** This field is **required**.

**Donor (Living or Deceased)  
Recipient**

**Donor ID:** The unique alphanumeric value assigned by the system when a donor is registered. This field is **required** if checkbox “Donor (Living or Deceased)” is selected.

**Have all of the recipient centers been notified at this time?:** This field is **required** if checkbox “Donor (Living or Deceased)” is selected.

**Yes  
No**

**Recipient SSN:** The recipient’s social security number. Numeric format XXXXXXXXX. This field is **required** if Recipient is selected.

**Waitlist ID:** The system-generated number assigned after a candidate is added to the waiting list. Numeric format XXXXXXXX. This field is **optional** if Recipient is selected.

**Donor ID of donor involved:** The unique 6- or 7-character alphanumeric value assigned by the system when a donor is registered. This field is **required** if Recipient is selected.

**Has the Host OPO been notified regarding this report?:** This field is **required** if Recipient is selected.

**Yes  
No**

**Reporting Institution:** Reporting member institution 4-digit code and name selected from the drop-down list. This field is **required**.

**Detected by:** This field is **required**.

**OPO before organs procured  
OPO after organs procured  
TX before organs procured  
TX after organs procured**

**Date Occurred:** Date the disease transmission occurred. MM/DD/YYYY format. This field is **required**.

**Infection/Malignancy/Other Medical Condition:** More than one may be selected.

Add Infection  
Add Malignancy  
Add Other Medical Condition

Add Infection

**Specify Type:** Values selected from a drop-down list. This field is **required**.

**Infection:** Value selected from a drop-down list. Up to four types may be selected. This field is **required**.

**Specify Type:**

Amoebic  
Bacterial  
Fungal  
Parasitic  
Viral

**Infection:**

Encephalitis (All Types)  
Endocarditis  
Fever of Unknown Origin (FUO)  
Meningitis (All Types)  
Pneumoniae  
Unknown Infection  
Other Specify  
Acinetobacter baumannii  
AFB-other  
Bacterial Emboli  
Brucella  
Citrobacter  
E. coli  
Ehrlichia  
Endocarditis  
Enterobacter asburiae  
Enterococcus (not VRE)  
Enterococcus (VRE)  
Gram Positive Cocci (GPC)  
Klebsiella  
Legionnaires Disease  
Listeria monocytogenes  
Lyme Disease  
Methicillin-resistant Staphylococcus aureus (MRSA)  
Methicillin-sensitive Staphylococcus aureus (MSSA)  
Mycobacterium Avium Complex (MAC)  
Mycobacterium Kansaii  
Mycobacterium (unknown)  
Mycobacterium abscessus  
Mycobacterium gordonae  
Mycobacterium intracellulare  
Mycoplasma hominis

**Mycobacterium tuberculosis (TB)**  
**Mycotic Aneurysm**  
**Neisseria meningitides**  
**Nocardia**  
**Pneumoniae**  
**Pseudomonas**  
**Salmonella**  
**Serratia**  
**Staphylococcus**  
**Streptococcus**  
**Syphilis**  
**Veilonella**  
**Aspergillus**  
**Blastomycosis**  
**Candida albicans**  
**Candida glabrata**  
**Candida tropicalis**  
**Candidiasis (unknown)**  
**Cryptococcus**  
**Coccidioides immitis (Valley Fever)**  
**Histoplasma/Histoplasmosis**  
**Rhizopus**  
**Zygomycete**  
**Amoebiasis**  
**Babesia**  
**Balamuthia mandrilli**  
**Chagas (T.cruzi)**  
**Leishmaniasis**  
**Schistosomiasis**  
**Strongyloides**  
**Toxoplasmosis**  
**Adenovirus**  
**Cytomegalovirus (CMV)**  
**Epstein-Barr virus (EBV)**  
**Hepatitis B (HBV)**  
**Hepatitis C (HCV)**  
**Hepatitis E**  
**Herpes Simplex Virus (HSV)**  
**Human herpesvirus 8 (HHV8)**  
**Human Immunodeficiency Virus (HIV)**  
**Human T-cell lymphotropic virus I (HTLV-I)**  
**Human T-cell lymphotropic virus II (HTLV-II)**  
**Influenza A – H1N1**  
**Influenza A (Not H1N1)**  
**Lymphocytic Choriomenigitis virus (LCMV)**  
**Parvo B19**  
**PIV3 ParaInfluenzaVirus**  
**Rabies**  
**Rhinovirus**  
**Viral Myocarditis**  
**West Nile Virus (WNV)**

**Date Detected:** Date the infection was detected. MM/DD/YYYY format. This field is required.

**At this time the diagnosis is:** This field is required.

Confirmed  
Suspected

Add Malignancy

**Malignancy:** Value selected from the drop-down list. Up to four types may be selected. This field is required.

Adenocarcinoma  
Adenocarcinoma Colon  
Adenocarcinoma Prostate  
Astrocytoma  
Basaloid CA  
Basal Cell  
Bladder CA  
Brain CA-Spindle Cell  
Breast Cancer  
Breast mass Bronchi-Aviolar CA  
Cholangiocarcinoma  
Chronic lymphocytic leukemia (CLL) Dermatofibrosarcoma Protuberans  
Epithelioid Angiomyolipoma  
Gastrointestinal stromal tumor (GIST)  
Glioblastoma  
Hepatocellular Carcinoma (HCC)  
Kaposi's Sarcoma  
Leukemia  
Liposarcoma  
Liver CA  
Lung CA  
Lymphoma Non-Hodgkins  
Malignant T-cell Lymphoma  
Medullablastoma  
Melanocytic Lesion  
Melanoma  
Mesothelioma  
Neuroendocrine CA  
Non-Small Cell Carcinoma  
Oncocytoma  
Ovarian CA  
Pancreatic CA  
Paraganglioma  
Pineoblastoma  
Prostate Cancer  
Renal Cell Carcinoma (RCC)  
Sarcoma Squamous Cell CA  
Small Bowel CA  
Small Cell CA  
Thyroid CA

Unknown CA  
Urothelial Cell CA  
Other Specify

**Date Detected:** Date the malignancy was detected. MM/DD/YYYY format. This field is required.

**At this time the diagnosis is:** This field is required.

Confirmed  
Suspected

**Add Other Medical Condition**

**Other Medical Condition:** Value selected from the drop-down list. Up to four types may be selected. This field is required.

Amyloidosis  
Creutzfeldt-Jakob Disease (CJD)  
Hemochromatosis  
Ornithine Transcarbamylase (OTC) Deficiency  
Peanut allergy  
Sarcoidosis  
Other – Specify

**Date Detected:** Date the condition was detected. MM/DD/YYYY format. This field is required.

**At this time the diagnosis is:** This field is required.

Confirmed  
Suspected

**Please attach any relevant documents, including lab or diagnostic testing results:**

**Choose File:** To upload supporting documentation to the event form. This is optional.  
Maximum file upload size: 20 MB.

**Was an assay or other test used to identify organism disease?:** This field is required.

Yes  
No  
Unknown

**Add Assay/Test Type**

**Assay/Test Type:** This field is required if checkbox “Yes” is selected in response to “Was an assay or other test used to identify organism disease?”.

Ab  
Acid Fast Smear  
Aerobic Cx  
AFB Cx

BAL  
Blood Cx  
Bone Marrow Bx  
Bronchial Bx  
Bronchial Lavage  
Bx  
Cell block  
Cell Ct & Diff  
CMV Stain  
CT of abd  
CT of chest  
CT of head  
CT of pelvis  
CXR  
Cytology  
DNA testing  
FISH  
Fluid Cx  
Fungal Cx  
Fungal stain  
GMS stains  
Gram stain  
IgG  
IgM  
Legionella DFA & Cx  
Molecular Fingerprinting  
MRI of abd  
MRI of chest  
MRI of head  
MRI of pelvis  
NAT  
PCR  
Pneumocystic IFA  
Pneumocystis Stain  
PPD  
Silver Stain  
Smear  
Sputum Cx  
Surface Antigen  
Urinalysis  
Urine Cx  
US of abd  
US of pelvis  
Viral Cx  
RNA  
Other – Specify

**Results:** Value selected from drop-down menu. This field is **required** if checkbox “Yes” is selected in response to “Was an assay or other test used to identify organism disease?”.

Positive  
Negative  
Indeterminate  
Other

**Date of test:** Date the test was completed. MM/DD/YYYY format. This field is **required** if checkbox “Yes” is selected in response to “Was an assay or other test used to identify organism disease?”

**Was the donor blood sample obtained pre or post transfusion?:** This field is **required** if checkbox “Yes” is selected in response to “Was an assay or other test used to identify organism disease?”

Pre  
Post  
Unknown

**What donor specimens remain for further testing? (Please indicate type and amount):** A free-text field to describe specimens available for testing. 5000 character limit. This field is **required**.

**Was tissue recovered from this donor?:** This field is **required**.

Yes  
No  
Unknown

**Was an autopsy completed on this donor? (Please upload a copy of the autopsy report if available):** This field is **required**.

Yes  
No  
Unknown

**Have local/state public health authorities been contacted regarding this event? (If appropriate for nationally notifiable infectious diseases as defined by the US Public Health Services):** This field is **required**.

Yes  
No  
Unknown

**Enter narrative description of the event:** A free-text field to enter a detailed description of the event or to explain any other choices selected elsewhere on the form. 5000 character limit. This field is **required**.

**Contact Information**

**Who is the patient safety contact at your institution for this event?**

**First Name:** First name of the institution’s patient safety contact. 50 character limit. This field is **required**.

**Last Name:** Last name of the institution’s patient safety contact. 50 character limit. This field is **required**.



**Phone contact (enter at least one): Office:** The office phone number of the institution's patient safety contact. Numeric format XXX-XXX-XXXX or XXXXXXXXXXXX. This field is **required**.

**ext.:** The extension of the office phone number. 10 character limit. This field is **optional**.

**Pager/Beeper:** The pager/beeper number of the institution's patient safety contact. Numeric format XXX-XXX-XXXX or XXXXXXXXXXXX. This field is **optional**.

**ext.:** The extension of the pager/beeper number. 10 character limit. This field is **optional**.

**Mobile:** The cell phone number of the institution's patient safety contact. Numeric format XXX-XXX-XXXX or XXXXXXXXXXXX. This field is **optional**.

**ext.:** The extension of the mobile number. 10 character limit. This field is **optional**.

**Email:** The email address of the institution's patient safety contact. 100 character limit. This field is **required**.

**Other contact info:** A free text field. 50 character limit. This field is **optional**.

**ext.:** The extension of the other contact info. 10 character limit. This field is **optional**.

**Person Submitting the Report:**

**First Name:** First name of the person submitting the report. 50 character limit. This field is **required**.

**Last Name:** Last name of the person submitting the report. 50 character limit. This field is **required**.

**Email:** The email address of the person submitting the report. 100 character limit. This field is **required**.

**Submit:** Select to submit form when entry is complete.

**Cancel:** Select to exit form before submitting an event. Any information entered on the form will be lost.