PEDIATRIC HEART TRANSPLANT STUDY

FORM 15: 2010: **Mechanical Circulatory Support Events** (PG 1 of 1)

To be filled out while waiting or post-transplant

ID# **P** | P | Institutional Code | Sequential Patient Number | Patient Initials | Tran #

To be completed at the time of initiation of any mechanical circulartory support (indicate "Original submission") OR at the time of change of mechanical circulartory support (indicate "Updated Submission").

☐ Original submission ☐ Updated submission

One "Event" should be completed for each type of mechanical support: ECMO, VAD, IABP, Impella.

EVENT A:

1. Date of Initiation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

2. Date of Discontinuation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

3. Type of Support:

a. ☐ ECMO Specify: ☐ V–V ☐ V–A

b. ☐ VAD Type: ☐ BIVAD ☐ LVAD alone ☐ RVAD alone Brand: _____

c. ☐ Other temp device Specify: ☐ IABP ☐ Impella ☐ Other: _____

EVENT B:

1. Date of Initiation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

2. Date of Discontinuation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

3. Type of Support:

a. ☐ ECMO Specify: ☐ V–V ☐ V–A

b. ☐ VAD Type: ☐ BIVAD ☐ LVAD alone ☐ RVAD alone Brand: _____

c. ☐ Other temp device Specify: ☐ IABP ☐ Impella ☐ Other: _____

EVENT C:

1. Date of Initiation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

2. Date of Discontinuation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

3. Type of Support:

a. ☐ ECMO Specify: ☐ V–V ☐ V–A

b. ☐ VAD Type: ☐ BIVAD ☐ LVAD alone ☐ RVAD alone Brand: _____

c. ☐ Other temp device Specify: ☐ IABP ☐ Impella ☐ Other: _____

EVENT D:

1. Date of Initiation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

2. Date of Discontinuation: (MO | DAY | YR) ☐☐ ☐☐ ☐☐

3. Type of Support:

a. ☐ ECMO Specify: ☐ V–V ☐ V–A

b. ☐ VAD Type: ☐ BIVAD ☐ LVAD alone ☐ RVAD alone Brand: _____

c. ☐ Other temp device Specify: ☐ IABP ☐ Impella ☐ Other: _____

Person completing this form: _____ Date original form mailed (do not send copy) _____

PRINT IN BLACK INK ONLY. USE THIS FORM FOR ALL PATIENTS OR EVENTS AFTER JANUARY 1, 2010