Pediatric Heart Transplant Study
Form 0899: Status Report

ID#P | | | | | | | | | | |

P	Institution Code	Sequential Patient Number	Patient Initials

1. Date of Follow-up (mon-day-yr): __ __ – __ __ – __ __

2a. Height _____ in / cm

2b. Weight _____ lb / kg

2. Hemodynamics: Date: __ __ - __ __ - __ __

AoS	AoD	AoM	RAm	PAs	PAd	PAm	PCW	C.O.	C.I.	QP:QS	Rp	Rs

4a. Current Patient Residence (check one below): **4b**. Current residence ZIP Code (5 digit only): ___ ___ ___ ___ ___

❑ Home ❑ Other (specify): _____)

5. Patient Medical Care (at time of this status report), check one primary heading then as applicable under that choice)

❑ a. Patient currently followed at our PHTS transplant center (if checked, then check one below indicating degree of care provided at PHTS center):

- ❑ Almost all (most) medical care is provided at our center.
- ❑ Transplant related care (cardiovascular) and/or severe illness care at our center, other care elsewhere.
- ❑ Only yearly evaluation at our center, we do not follow PHTS events.

If checked, indicate date PHTS event follow-up ceased: ___ ___ - ___ ___ - ___ ___

If some care by other center/physician, specify center & location:

_____

❑ b. Patient followed exclusively at another center: (specify center and location, city/state):

_____

Specify date of last follow-up at your center. ___ ___ - ___ ___ - ___ ___

6. Non PHTS center care: Please indicate reason for **any** care being provided at another center (if chosen above):

- ❑ Patient desire, not related to location
- ❑ Patient residence location, financial concerns (not due solely to medical care costs)
- ❑ Patient residence location, convenience
- ❑ Care shifted to another center after transplant per contract with 3rd party payer (mandated by contract). (if so, date of care shift: ___ ___ - ___ ___ - ___ ___)
- ❑ Other reason(s), specify: _____

7. Trough **level** (on current dose listed below): Drug: ❑ Cyclosporine ❑ Tacrolimus **Level:** _____

Date: _ _ / _ _ / _ _ (may be after date of this form) ❑Serum ❑Whole Blood Method of Level (specify):_____

8.Medications(List all current meds ❑ see reverse

25. Development:
Cerebral Outcome Score: _____ (1-5)

26. Schooling
❑ Age appropriate ❑ Special School

27. Exercise Capacity
❑ Normal
❑ Impaired: (❑ mild ❑ severe)

28. Treadmill Test
Resting BP: ____ / ____ HR: ____
Maximum: duration: _____ min
Max BP: ____ / ____ HR: ___
% of Predicted for Age: _____

29. O.F.C. _____ cm (up to age 3 years)
(occipital - frontal circumference)

9. Additional Immunosuppressive Therapy Since last status report (Form 08 completed) or since Transplant:

❑ Total Lymphoid Irrad: Total Dose: ____ cGy ❑ Plasmapheresis ❑ Photopheresis ❑ Other,specify:_____

10.Insurance: a. Primary (check one): Medicare:(❑State❑HMO) Medicaid:(❑State❑HMO) ❑Other Gov ❑Private ❑Self ❑donation ❑Free ❑Other, on back

11.Serum Lipids / Labs: Date Performed, (nearest this report due date): __ __ - __ __ - __ __ (print "NA" in spaces if not done)

Chol	TG	LDL	HDL	VLDL	LPa	IDL	HDL2	HDL3	BUN	Creat	T Protein	SerAlbumin

12. Medical / Surgical Problems Since Last Report

	Dt:___-___-___	Dt:___-___-___
Dt:___-___-___	Dt:___-___-___	Dt:___-___-___
Dt:___-___-___	Dt:___-___-___	Dt:___-___-___

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, 1999.

2/14/99 RCB