Pediatric Heart Transplant Study

FORM 01:05: Initial Patient Entry at Listing (Page 1of 2)

ID# P [ ][ ][ ] [ ][ ][ ][ ] [ ][ ][ ]

P	Institution Code	Sequential Patient Number	Patient Initials

PRINT IN BLACK INK ONLY: USE THIS FORM FOR ALL PATIENTS OR EVENTS AFTER JANUARY 1.2005

1. Institution Code: ___ ___ ___

2. Patient Number: ___ ___ ___ ___

3. Patient Initials: ___ ___ ___

4. Height: _____ ☐in ☐ cm

Weight: ______ ☐lb ☐kg

5. Date of Birth: (mo-day-yr) [ ][ ][ ][ ][ ][ ]

6. Date Listed: (mo-day-yr) [ ][ ][ ][ ][ ][ ]

7. Gender: ☐ Male ☐ Female

8a. Race: (See Manual, check all that apply) ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ Mid-east/Arabian ☐ Indian Subcontinent ☐ Other, specify:____________________

8b. Hispanic Origin: ☐ Yes ☐ No

9. Etiology: ☐ Myocarditis

☐ Cardiomyopathy (if checked, complete below):
- ☐ Adriamycin-induced
- ☐ Dilated, idiopathic
- ☐ Hypertrophic
- ☐ Ischemic, Kawasaki Disease
- ☐ Ischemic, Other _____________
- ☐ LV noncompaction
- ☐ Metabolic
- ☐ Restrictive
- ☐ Other, specify ______________

☐ Congenital Heart Disease:(if checked, complete below):
- ☐ Complete AV Septal Defect
- ☐ Congenitally Corrected Transposition
- ☐ Ebstein's Anamoly
- ☐ Hypoplastic Left Heart
- ☐ Left Heart Valvar/Structural Hypoplasia
- ☐ Pulmonary Atresia with IVS
- ☐ Single Ventricle
- ☐ TOF/DORV/RVOTO
- ☐ Transposition of the Great Arteries
- ☐ Truncus Arteriosus
- ☐ VSD/ASD
- ☐ Other, specify ____________________

10a. Surgical History: ☐ No Previous Surgery

☐Previous Sternotomy(s): Number: _____

☐Previous Thoracotomy(s): Number: _____

*Choose **Surgical Codes** at right. Please list code and date of surgery in chronological order.*

10b. Date (at least year)

	Code	Date
1.	____	____-____-____
2.	____	____-____-____
3.	____	____-____-____
4.	____	____-____-____
5.	____	____-____-____
6.	____	____-____-____
7.	____	____-____-____

Surgical Codes:
1. AP Shunt
2. ASD Repair
3. Complete AV Septal Defect Repair
4. Congenitally Corrected Transposition Repair
5. Damus Kaye Stansel (DKS)
6. Ebstein's Anamoly Repair
7. Fontan
8. Glenn, Bi-directional
9. Glenn, Classical
10. Norwood Stage I
11. PA Banding
12. TOF/DORV/RVOTO Repair
13. Transposition of the Great Vessels Repair
14. Truncus Arteriosus Repair
15. Valve Replacement or Repair for Outflow Obstruction
16. VSD Repair
17. Other, specify _________________

11. Status AT Listing: (Verify with OPO) ☐ 1A ☐ 1B ☐ 2 ☐ Other, Specify:_______ Canadian Status: ________

Check All Status Details That Apply Per UNOS Policy 3.7 or 1/20/99:

☐ Status 1A, life expect <7 days (UNOS Policy 3.7.4.f)

☐ In Hospital ☐Out Hospital ☐ICU ☐IV Inotropes, high ☐IV Inotropes, low ☐Hemo Monitoring ☐ Ventilator ☐ IABP

☐ <6 mon old, pulmonary hypertension >50% systemic pressure

☐ <6 mon old, pulmonary hypertension <50% systemic pressure

☐ Growth Failure due to acquired or congenital heart disease

☐ VAD/TAH Date 1st Placed: ___-___-___ ☐ECMO: Date Placed: ___-___-___

☐ Type: ☐ Right ☐ Left, ☐ Both, ☐ TAH Brand/Model: ______________________________

12. Infectious Disease Screening						
	General	HIV: ☐Pos ☐Neg ☐NA	IFA Toxo: ☐Pos ☐Neg ☐NA	RPR: ☐Pos ☐Neg ☐NA	Hepatitis	HBs Ag: ☐Pos ☐Neg ☐NA	HBs Ab ☐Pos ☐Neg ☐NA
		CMV IgG: ☐Pos ☐Neg ☐NA	EBV IgG: ☐Pos ☐Neg ☐NA			HB core Ab ☐Pos ☐Neg ☐NA	Hep C Ab ☐Pos ☐Neg ☐NA

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ID# P ☐☐☐ ☐☐☐☐ ☐☐☐

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13a. Blood Type, Patient: ☐ A ☐ B ☐ AB ☐ O

13b. Rh: ☐ Pos ☐ Neg

14. Med Hx (check all that apply)

☐ Arrhythmia (check below)
 ☐ Afib/flutter ☐ V Tach ☐ VFib
 ☐ Complete Ht Block
 ☐ Other, specify _____________
☐ Asthma
☐ CPR: Date Last ___/___
☐ CVA: Date Last ___/___
☐ Diabetes
☐ Failure to thrive
☐ Hepatitis: Dt dx: ___/___
☐ Hypertension: Dt dx: ___/___
☐ Malignancy, type: __________
☐ Pacemaker: Date 1st placed: ___/___
☐ Peripheral Myopathy
☐ Prenatal Diagnosis
☐ Prior Transfusions
☐ Protein Losing Enteropathy
☐ Renal Insufficiency
☐ Shock: Date Last: ___/___
☐ Other: __________

15a. Primary Insurance (check one): Medicaid (☐State ☐HMO) ☐Other Gov ☐Private ☐Self ☐Donation ☐Free ☐Other ____________________

15b. Secondary Insurance (check all that apply): Medicaid (☐State ☐HMO) ☐Other Gov ☐Private ☐Self ☐Donation ☐Free ☐Other ____________________

16. Percent or Panel Reactive Antibody (closest to listing): PRA, AHG-Enhanced: ☐Yes ☐No ☐Unknown

16a. Cytotoxic PRA: T Cell _____% B Cell _____% Date: ___-___-___ ☐Not Done
16b. Cytotoxic PRA, DTE/DTT: T Cell _____% B Cell _____% Date: ___-___-___ ☐Not Done
16c. Flow Cytometry PRA: Class I _____% Class II _____% Date: ___-___-___ ☐Not Done
16d. ELISA: Class I _____% Class II _____% Date: ___-___-___ ☐Not Done
16e. Other: Specify Method Results and Units ____________________________________ Date: ___-___-___ ☐Not Done

17a. Hemodynamics at listing:

	Best
Ram	
PAm	
PCW	
C.O.	
C.I.	
Qp/Qs	
Rp	
Rs	
AO Sat	
Date:	____-____-____

17b. Indicate agents for best Hemodynamics:

☐ None
☐ 100% O2
☐ Dopamine
☐ Dobutamine
☐ Amrinone (Inocor)
☐ Milrinone (Primacor)
☐ Isuproterenol (Isuprel)
☐ PGE (Alprostadil)
☐ PGI (Flolan)
☐ Nesiritide
☐ Nitroglycerine
☐ Nitroprusside (Nipride)
☐ Nitric Oxide
☐ Others, specify:
____
____
____

18. Schooling

☐ Within one grade level
☐ Delayed grade level
☐ Special education
☐ Not applicable, <6 years
☐ Status unknown

19. Treadmill Test

☐ Not Done
Resting BP: ____/____
HR: ____
Maximum: duration: ______ min
Max. BP: ____/____
HR: ____
% Predicted for Age: _______
Max. VO_2 _________ ml/kg/min

20. Serum Albumin (closest to listing): _____________ Date: ____-_____-_____
21. Total Protein (closest to listing): _____________ Date: ____-_____-_____
22. NYHA or Ross' Heart Failure: ☐ Not Done
 NYHA Class: ☐ I ☐ II ☐ III ☐ IV
 Ross Heart Failure Class: ☐ I ☐ II ☐ III ☐ IV
23. MvO2 _________ cc/kg Date ____-____-____
24. Liver Function Tests:
 Bilirubin (total/direct) _______
 AST _______
 ALT _______

Person Completing this form: ___________________________

Date Original Form Mailed (do not send copy): ___________

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